

ORIGINAL

14-020

**ILLINOIS HEALTH FACILITIES AND SERVICES REVIEW BOARD
APPLICATION FOR PERMIT****RECEIVED****SECTION I. IDENTIFICATION, GENERAL INFORMATION, AND CERTIFICATION**

MAY 16 2014

This Section must be completed for all projects.**HEALTH FACILITIES &
SERVICES REVIEW BOARD****Facility/Project Identification**

Facility Name: Chicago Ridge Dialysis		
Street Address: 10511 South Harlem Avenue		
City and Zip Code: Worth, Illinois 60482		
County: Cook	Health Service Area: 7	Health Planning Area: 7

Applicant /Co-Applicant Identification**[Provide for each co-applicant [refer to Part 1130.220].**

Exact Legal Name: DaVita HealthCare Partners Inc.
Address: 2000 16 th Street, Denver, CO 80202
Name of Registered Agent: Illinois Corporation Service Company
Name of Chief Executive Officer: Kent Thiry
CEO Address: 2000 16 th Street, Denver, CO 80202
Telephone Number: (303) 405-2100

Type of Ownership of Applicant/Co-Applicant

<input type="checkbox"/> Non-profit Corporation	<input type="checkbox"/> Partnership
<input checked="" type="checkbox"/> For-profit Corporation	<input type="checkbox"/> Governmental
<input type="checkbox"/> Limited Liability Company	<input type="checkbox"/> Sole Proprietorship
<input type="checkbox"/> Other	

- Corporations and limited liability companies must provide an **Illinois certificate of good standing**.
- Partnerships must provide the name of the state in which organized and the name and address of each partner specifying whether each is a general or limited partner.

APPEND DOCUMENTATION AS ATTACHMENT-1 IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.**Primary Contact****[Person to receive ALL correspondence or inquiries]**

Name: Tim Tincknell
Title: Administrator, CON Projects
Company Name: DaVita HealthCare Partners, Inc.
Address: 1333 North Kingsbury Street, Suite 305, Chicago, Illinois 60642
Telephone Number: 312-649-9289
E-mail Address: timothy.tincknell@davita.com
Fax Number: 866-586-3214

Additional Contact**[Person who is also authorized to discuss the application for permit]**

Name: Ronny Philip
Title: Regional Operations Director
Company Name: DaVita HealthCare Partners Inc.
Address: 13155 South LaGrange Road, Orland Park, Illinois 60462
Telephone Number: 708-923-0928
E-mail Address: ronny.philip@davita.com
Fax Number: 855-871-6348

ILLINOIS HEALTH FACILITIES AND SERVICES REVIEW BOARD APPLICATION FOR PERMIT

SECTION I. IDENTIFICATION, GENERAL INFORMATION, AND CERTIFICATION

This Section must be completed for all projects.

Facility/Project Identification

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Applicant /Co-Applicant Identification

[Provide for each co-applicant [refer to Part 1130.220].

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Name of Registered Agent: Illinois Corporation Service Company
Name of Chief Executive Officer: Kent Thiry
CEO Address: 2000 16 th Street, Denver, CO 80202
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Fax Number: 855-871-6348

Post Permit Contact

[Person to receive all correspondence subsequent to permit issuance-**THIS PERSON MUST BE EMPLOYED BY THE LICENSED HEALTH CARE FACILITY AS DEFINED AT 20 ILCS 3960**

Name: Charles Sheets
Title: Attorney
Company Name: Polsinelli PC
Address: 161 North Clark Street, Suite 4200, Chicago, Illinois 60601
Telephone Number: 312-873-3605
E-mail Address: csheets@polsinelli.com
Fax Number: 312-873-3793

Site Ownership

[Provide this information for each applicable site]

Exact Legal Name of Site Owner: Palestra Real Estate Partners, Inc
Address of Site Owner: 808 Montparnasse Place, Newtown Square, PA 19073
Street Address or Legal Description of Site: This site is comprised of two tax parcels, as described on the legal descriptions set forth below:
<p>Tax Parcel One:</p> <p>The west 65.80 feet (measured perpendicular to the west line) of Lot 1 in Aldi subdivision, being a subdivision of part of the northwest ¼ of Section 18, Township 37 North, Range 13, east of the Third Principal Meridian, according to the Plat thereof recorded June 18, 1990 as document number 90-287592, in Cook County, Illinois.</p> <p>Tax Parcel Four:</p> <p>Lot 1 (except the west 65.80 feet measured perpendicular to the west line thereof) in Aldi subdivision being a subdivision of part of the northwest ¼ of Section 18, Township 37 North, Range 13, east of the Third Principal Meridian, according to the Plat thereof recorded June 18, 1990 as document number 90-287592, in Cook County, Illinois.</p>
APPEND DOCUMENTATION AS ATTACHMENT-2, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

Operating Identity/Licensee

[Provide this information for each applicable facility, and insert after this page.]

Exact Legal Name: Cagles Dialysis, LLC		
Address: 2000 16 th Street, Denver, CO 80202		
<input type="checkbox"/> Non-profit Corporation	<input type="checkbox"/> Partnership	
<input type="checkbox"/> For-profit Corporation	<input type="checkbox"/> Governmental	
<input checked="" type="checkbox"/> Limited Liability Company	<input type="checkbox"/> Sole Proprietorship	<input type="checkbox"/> Other
<ul style="list-style-type: none"> o Corporations and limited liability companies must provide an Illinois Certificate of Good Standing. o Partnerships must provide the name of the state in which organized and the name and address of each partner specifying whether each is a general or limited partner. o Persons with 5 percent or greater interest in the licensee must be identified with the % of ownership. 		
APPEND DOCUMENTATION AS ATTACHMENT-3, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.		

Organizational Relationships

Provide (for each co-applicant) an organizational chart containing the name and relationship of any

person or entity who is related (as defined in Part 1130.140). If the related person or entity is participating in the development or funding of the project, describe the interest and the amount and type of any financial contribution.

APPEND DOCUMENTATION AS ATTACHMENT-4, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

Flood Plain Requirements

[Refer to application instructions.]

Provide documentation that the project complies with the requirements of Illinois Executive Order #2005-5 pertaining to construction activities in special flood hazard areas. As part of the flood plain requirements please provide a map of the proposed project location showing any identified floodplain areas. Floodplain maps can be printed at www.FEMA.gov or www.illinoisfloodmaps.org. **This map must be in a readable format.** In addition please provide a statement attesting that the project complies with the requirements of Illinois Executive Order #2005-5 (<http://www.hfsrb.illinois.gov>).

APPEND DOCUMENTATION AS **ATTACHMENT -5**, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

Historic Resources Preservation Act Requirements

[Refer to application instructions.]

Provide documentation regarding compliance with the requirements of the Historic Resources Preservation Act.

APPEND DOCUMENTATION AS **ATTACHMENT-6**, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

DESCRIPTION OF PROJECT**1. Project Classification**

[Check those applicable - refer to Part 1110.40 and Part 1120.20(b)]

Part 1110 Classification:

- ☒ Substantive
☐ Non-substantive

2. Narrative Description

Provide in the space below, a brief narrative description of the project. Explain **WHAT** is to be done in **State Board defined terms**, **NOT WHY** it is being done. If the project site does NOT have a street address, include a legal description of the site. Include the rationale regarding the project's classification as substantive or non-substantive.

DaVita HealthCare Partners Inc. and Cagles Dialysis, LLC (the "Applicants") seek authority from the Illinois Health Facilities and Services Review Board (the "Board") to establish a 16-station dialysis facility located at 10511 South Harlem Avenue, Worth, Illinois 60482. The proposed dialysis facility will include a total of 7,423 gross square feet.

This project has been classified as substantive because it involves the establishment of a health care facility.

Project Costs and Sources of Funds

Complete the following table listing all costs (refer to Part 1120.110) associated with the project. When a project or any component of a project is to be accomplished by lease, donation, gift, or other means, the fair market or dollar value (refer to Part 1130.140) of the component must be included in the estimated project cost. If the project contains non-reviewable components that are not related to the provision of health care, complete the second column of the table below. Note, the use and sources of funds must equal.

Project Costs and Sources of Funds			
USE OF FUNDS	CLINICAL	NONCLINICAL	TOTAL
Preplanning Costs			
Site Survey and Soil Investigation			
Site Preparation			
Off Site Work			
New Construction Contracts			
Modernization Contracts	\$1,025,000		\$1,025,000
Contingencies	\$148,625		\$148,625
Architectural/Engineering Fees	\$86,000		\$86,000
Consulting and Other Fees	\$53,500		\$53,500
Movable or Other Equipment (not in construction contracts)	\$595,000		\$595,000
Bond Issuance Expense (project related)			
Net Interest Expense During Construction (project related)			
Fair Market Value of Leased Space or Equipment	\$1,586,428		\$1,586,428
Other Costs To Be Capitalized			
Acquisition of Building or Other Property (excluding land)			
TOTAL USES OF FUNDS	\$3,494,553		\$3,494,553
SOURCE OF FUNDS	CLINICAL	NONCLINICAL	TOTAL
Cash and Securities	\$1,908,125		\$1,908,125
Pledges			
Gifts and Bequests			
Bond Issues (project related)			
Mortgages			
Leases (fair market value)	\$1,586,428		\$1,586,428
Governmental Appropriations			
Grants			
Other Funds and Sources			
TOTAL SOURCES OF FUNDS	\$3,494,553		\$3,494,553
NOTE: ITEMIZATION OF EACH LINE ITEM MUST BE PROVIDED AT ATTACHMENT-7, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.			

Related Project Costs

Provide the following information, as applicable, with respect to any land related to the project that will be or has been acquired during the last two calendar years:

Land acquisition is related to project ☐ Yes ☒ No
Purchase Price: \$ _____
Fair Market Value: \$ _____

The project involves the establishment of a new facility or a new category of service
☒ Yes ☐ No

If yes, provide the dollar amount of all **non-capitalized** operating start-up costs (including operating deficits) through the first full fiscal year when the project achieves or exceeds the target utilization specified in Part 1100.

Estimated start-up costs and operating deficit cost is \$ 1,779,779.

Project Status and Completion Schedules

For facilities in which prior permits have been issued please provide the permit numbers.

Indicate the stage of the project's architectural drawings:

☐ None or not applicable ☐ Preliminary
☒ Schematics ☐ Final Working

Anticipated project completion date (refer to Part 1130.140): January 31, 2016

Indicate the following with respect to project expenditures or to obligation (refer to Part 1130.140):

- ☐ Purchase orders, leases or contracts pertaining to the project have been executed.
☐ Project obligation is contingent upon permit issuance. Provide a copy of the contingent "certification of obligation" document, highlighting any language related to CON Contingencies
☒ Project obligation will occur after permit issuance.

APPEND DOCUMENTATION AS ATTACHMENT-8, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

State Agency Submittals

Are the following submittals up to date as applicable:

- ☐ Cancer Registry
☐ APORS
☒ All formal document requests such as IDPH Questionnaires and Annual Bed Reports been submitted
☒ All reports regarding outstanding permits

Failure to be up to date with these requirements will result in the application for permit being deemed incomplete.

Cost Space Requirements

Provide in the following format, the department/area **DGSF** or the building/area **BGSF** and cost. The type of gross square footage either **DGSF** or **BGSF** must be identified. The sum of the department costs **MUST** equal the total estimated project costs. Indicate if any space is being reallocated for a different purpose. Include outside wall measurements plus the department's or area's portion of the surrounding circulation space. **Explain the use of any vacated space.**

Dept. / Area	Cost	Gross Square Feet		Amount of Proposed Total Gross Square Feet That Is:			
		Existing	Proposed	New Const.	Modernized	As Is	Vacated Space
REVIEWABLE							
Medical Surgical							
Intensive Care							
Diagnostic Radiology							
MRI							
Total Clinical							
NON REVIEWABLE							
Administrative							
Parking							
Gift Shop							
Total Non-clinical							
TOTAL							
APPEND DOCUMENTATION AS ATTACHMENT-9, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.							

Facility Bed Capacity and Utilization

Complete the following chart, as applicable. Complete a separate chart for each facility that is a part of the project and insert following this page. Provide the existing bed capacity and utilization data for the latest **Calendar Year for which the data are available**. Include **observation days in the patient day totals for each bed service**. Any bed capacity discrepancy from the Inventory will result in the application being deemed **incomplete**.

FACILITY NAME:		CITY:			
REPORTING PERIOD DATES:					
		From:		to:	
Category of Service	Authorized Beds	Admissions	Patient Days	Bed Changes	Proposed Beds
Medical/Surgical					
Obstetrics					
Pediatrics					
Intensive Care					
Comprehensive Physical Rehabilitation					
Acute/Chronic Mental Illness					
Neonatal Intensive Care					
General Long Term Care					
Specialized Long Term Care					
Long Term Acute Care					
Other ((identify))					
TOTALS:					

CERTIFICATION

The application must be signed by the authorized representative(s) of the applicant entity. The authorized representative(s) are:

- in the case of a corporation, any two of its officers or members of its Board of Directors;
- in the case of a limited liability company, any two of its managers or members (or the sole manager or member when two or more managers or members do not exist);
- in the case of a partnership, two of its general partners (or the sole general partner, when two or more general partners do not exist);
- in the case of estates and trusts, two of its beneficiaries (or the sole beneficiary when two or more beneficiaries do not exist); and
- in the case of a sole proprietor, the individual that is the proprietor.

This Application for Permit is filed on the behalf of DaVita HealthCare Partners Inc. *
in accordance with the requirements and procedures of the Illinois Health Facilities Planning Act. The undersigned certifies that he or she has the authority to execute and file this application for permit on behalf of the applicant entity. The undersigned further certifies that the data and information provided herein, and appended hereto, are complete and correct to the best of his or her knowledge and belief. The undersigned also certifies that the permit application fee required for this application is sent herewith or will be paid upon request.

SIGNATURE

Arturo Sida

PRINTED NAME

Assistant Corporate Secretary

PRINTED TITLE

Notarization:

Subscribed and sworn to before me
this ____ day of ____

Signature of Notary

Seal

*Insert EXACT legal name of the applicant

SIGNATURE

Michael D Staffieri

PRINTED NAME

Chief Operating Officer – Kidney Care

PRINTED TITLE

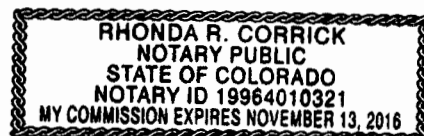
STATE OF COLORADO
COUNTY OF DENVER

Notarization:

Subscribed and sworn to before me
this 1ST day of APRIL, 2014

Signature of Notary

Seal



State of California

County of Los AngelesOn April 3, 2014 before me, Kimberly Ann K. Burgo, Notary Public

(here insert name and title of the officer)

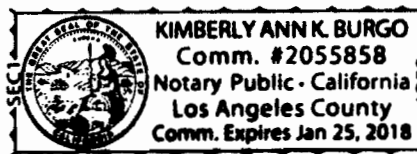
personally appeared Arturo Sida

who proved to me on the basis of satisfactory evidence to be the person(s) whose name(s) is/are subscribed to the within instrument and acknowledged to me that he/she/they executed the same in his/her/their authorized capacity(ies), and that by his/her/their signature(s) on the instrument the person(s), or the entity upon behalf of which the person(s) acted, executed the instrument.

I certify under PENALTY OF PERJURY under the laws of the State of California that the foregoing paragraph is true and correct.

WITNESS my hand and official seal.

Signature

Kimberly Ann K. Burgo

(Seal)

OPTIONAL INFORMATION

Law does not require the information below. This information could be of great value to any person(s) relying on this document and could prevent fraudulent and/or the reattachment of this document to an unauthorized document(s)

DESCRIPTION OF ATTACHED DOCUMENTTitle or Type of Document: Secretary's Certificate - DaVita HealthCare Partners Inc.Document Date: April 3, 2014Number of Pages: one (1)Signer(s) if Different Than Above: No

Other Information: _____

CAPACITY(IES) CLAIMED BY SIGNER(S)Signer's Name(s): Arturo Sida☐ Individual☒ Corporate Officer

(Title(s))

☐ Partner☐ Attorney-in-Fact☐ Trustee☐ Guardian/Conservator☒ Other: Assistant Corporate Secretary**SIGNER IS REPRESENTING:**Name of Person(s) or Entity(ies): DaVita HealthCare Partners Inc.

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SIGNATURE

Arturo Sida

PRINTED NAME

Assistant Corporate Secretary

PRINTED TITLE

Notarization:
Subscribed and sworn to before me
this ____ day of APRIL


Signature of Notary

Seal


SIGNATURE

Michael D Staffieri

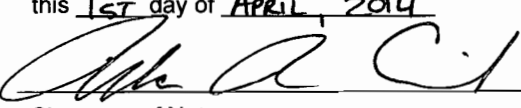
PRINTED NAME

Chief Operating Officer – Kidney Care

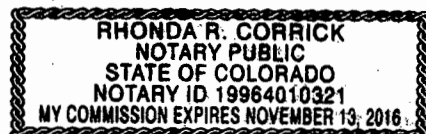
PRINTED TITLE

STATE OF COLORADO
COUNTY OF DENVER

Notarization:
Subscribed and sworn to before me
this 1ST day of APRIL, 2014


Signature of Notary

Seal



*Insert EXACT legal name of the applicant

State of California

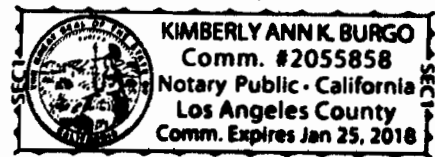
County of Los AngelesOn April 3, 2014 before me, Kimberly Ann K. Burgo, Notary Public
(here insert name and title of the officer)personally appeared Arturo Sida

who proved to me on the basis of satisfactory evidence to be the person(s) whose name(s) is/are subscribed to the within instrument and acknowledged to me that he/she/they executed the same in his/her/their authorized capacity(ies), and that by his/her/their signature(s) on the instrument the person(s), or the entity upon behalf of which the person(s) acted, executed the instrument.

I certify under PENALTY OF PERJURY under the laws of the State of California that the foregoing paragraph is true and correct.

WITNESS my hand and official seal.

Signature

Kimberly Ann K. Burgo

(Seal)

OPTIONAL INFORMATION

Law does not require the information below. This information could be of great value to any person(s) relying on this document and could prevent fraudulent and/or the reattachment of this document to an unauthorized document(s)

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Other Information: _____

CAPACITY(IES) CLAIMED BY SIGNER(S)Signer's Name(s): Arturo Sida☐ Individual☒ Corporate Officer

(Title(s))

☐ Partner☐ Attorney-in-Fact☐ Trustee☐ Guardian/Conservator☒ Other: Assistant Corporate Secretary**SIGNER IS REPRESENTING:**Name of Person(s) or Entity(ies): Cagles Dialysis, LLC

SECTION III – BACKGROUND, PURPOSE OF THE PROJECT, AND ALTERNATIVES - INFORMATION REQUIREMENTS

This Section is applicable to all projects except those that are solely for discontinuation with no project costs.

Criterion 1110.230 – Background, Purpose of the Project, and Alternatives

READ THE REVIEW CRITERION and provide the following required information:

BACKGROUND OF APPLICANT

1. A listing of all health care facilities owned or operated by the applicant, including licensing, and certification if applicable.
2. A certified listing of any adverse action taken against any facility owned and/or operated by the applicant during the three years prior to the filing of the application.
3. Authorization permitting HFSRB and DPH access to any documents necessary to verify the information submitted, including, but not limited to: official records of DPH or other State agencies; the licensing or certification records of other states, when applicable; and the records of nationally recognized accreditation organizations. **Failure to provide such authorization shall constitute an abandonment or withdrawal of the application without any further action by HFSRB.**
4. If, during a given calendar year, an applicant submits more than one application for permit, the documentation provided with the prior applications may be utilized to fulfill the information requirements of this criterion. In such instances, the applicant shall attest the information has been previously provided, cite the project number of the prior application, and certify that no changes have occurred regarding the information that has been previously provided. The applicant is able to submit amendments to previously submitted information, as needed, to update and/or clarify data.

APPEND DOCUMENTATION AS ATTACHMENT-11, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM. EACH ITEM (1-4) MUST BE IDENTIFIED IN ATTACHMENT 11.

PURPOSE OF PROJECT

1. Document that the project will provide health services that improve the health care or well-being of the market area population to be served.
2. Define the planning area or market area, or other, per the applicant's definition.
3. Identify the existing problems or issues that need to be addressed, as applicable and appropriate for the project. [See 1110.230(b) for examples of documentation.]
4. Cite the sources of the information provided as documentation.
5. Detail how the project will address or improve the previously referenced issues, as well as the population's health status and well-being.
6. Provide goals with quantified and measurable objectives, with specific timeframes that relate to achieving the stated goals **as appropriate**.

For projects involving modernization, describe the conditions being upgraded if any. For facility projects, include statements of age and condition and regulatory citations if any. For equipment being replaced, include repair and maintenance records.

NOTE: Information regarding the "Purpose of the Project" will be included in the State Board Report.

APPEND DOCUMENTATION AS ATTACHMENT-12, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM. EACH ITEM (1-6) MUST BE IDENTIFIED IN ATTACHMENT 12.

ALTERNATIVES

- 1) Identify **ALL** of the alternatives to the proposed project:

Alternative options **must** include:

- A) Proposing a project of greater or lesser scope and cost;
 - B) Pursuing a joint venture or similar arrangement with one or more providers or entities to meet all or a portion of the project's intended purposes; developing alternative settings to meet all or a portion of the project's intended purposes;
 - C) Utilizing other health care resources that are available to serve all or a portion of the population proposed to be served by the project; and
 - D) Provide the reasons why the chosen alternative was selected.
- 2) Documentation shall consist of a comparison of the project to alternative options. The comparison shall address issues of total costs, patient access, quality and financial benefits in both the short term (within one to three years after project completion) and long term. This may vary by project or situation. **FOR EVERY ALTERNATIVE IDENTIFIED THE TOTAL PROJECT COST AND THE REASONS WHY THE ALTERNATIVE WAS REJECTED MUST BE PROVIDED.**
- 3) The applicant shall provide empirical evidence, including quantified outcome data that verifies improved quality of care, as available.

APPEND DOCUMENTATION AS ATTACHMENT-13, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

SECTION IV - PROJECT SCOPE, UTILIZATION, AND UNFINISHED/SHELL SPACE**Criterion 1110.234 - Project Scope, Utilization, and Unfinished/Shell Space**

READ THE REVIEW CRITERION and provide the following information:

SIZE OF PROJECT:

1. Document that the amount of physical space proposed for the proposed project is necessary and not excessive. **This must be a narrative.**
2. If the gross square footage exceeds the BGSF/DGSF standards in Appendix B, justify the discrepancy by documenting one of the following::
 - a. Additional space is needed due to the scope of services provided, justified by clinical or operational needs, as supported by published data or studies;
 - b. The existing facility's physical configuration has constraints or impediments and requires an architectural design that results in a size exceeding the standards of Appendix B;
 - c. The project involves the conversion of existing space that results in excess square footage.

Provide a narrative for any discrepancies from the State Standard. A table must be provided in the following format with Attachment 14.

SIZE OF PROJECT				
DEPARTMENT/SERVICE	PROPOSED BGSF/DGSF	STATE STANDARD	DIFFERENCE	MET STANDARD?

APPEND DOCUMENTATION AS ATTACHMENT-14, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

PROJECT SERVICES UTILIZATION:

This criterion is applicable only to projects or portions of projects that involve services, functions or equipment for which HFSRB has established utilization standards or occupancy targets in 77 Ill. Adm. Code 1100.

Document that in the second year of operation, the annual utilization of the service or equipment shall meet or exceed the utilization standards specified in 1110. Appendix B. **A narrative of the rationale that supports the projections must be provided.**

A table must be provided in the following format with Attachment 15.

UTILIZATION					
	DEPT./ SERVICE	HISTORICAL UTILIZATION (PATIENT DAYS) (TREATMENTS) ETC.	PROJECTED UTILIZATION	STATE STANDARD	MET STANDARD?
YEAR 1					
YEAR 2					

APPEND DOCUMENTATION AS ATTACHMENT-15, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

UNFINISHED OR SHELL SPACE:

Provide the following information:

1. Total gross square footage of the proposed shell space;
2. The anticipated use of the shell space, specifying the proposed GSF to be allocated to each department, area or function;
3. Evidence that the shell space is being constructed due to
 - a. Requirements of governmental or certification agencies; or
 - b. Experienced increases in the historical occupancy or utilization of those areas proposed to occupy the shell space.
4. Provide:
 - a. Historical utilization for the area for the latest five-year period for which data are available; and
 - b. Based upon the average annual percentage increase for that period, projections of future utilization of the area through the anticipated date when the shell space will be placed into operation.

APPEND DOCUMENTATION AS ATTACHMENT-16, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

ASSURANCES:

Submit the following:

1. Verification that the applicant will submit to HFSRB a CON application to develop and utilize the shell space, regardless of the capital thresholds in effect at the time or the categories of service involved.
2. The estimated date by which the subsequent CON application (to develop and utilize the subject shell space) will be submitted; and
3. The anticipated date when the shell space will be completed and placed into operation.

APPEND DOCUMENTATION AS ATTACHMENT-17, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

G. Criterion 1110.1430 - In-Center Hemodialysis

1. Applicants proposing to establish, expand and/or modernize In-Center Hemodialysis must submit the following information:
2. Indicate station capacity changes by Service: Indicate # of stations changed by action(s):

Category of Service	# Existing Stations	# Proposed Stations
<input checked="" type="checkbox"/> In-Center Hemodialysis	0	16

3. READ the applicable review criteria outlined below and **submit the required documentation for the criteria:**

APPLICABLE REVIEW CRITERIA	Establish	Expand	Modernize
1110.1430(b)(1) - Planning Area Need - 77 Ill. Adm. Code 1100 (formula calculation)	X		
1110.1430(b)(2) - Planning Area Need - Service to Planning Area Residents	X	X	
1110.1430(b)(3) - Planning Area Need - Service Demand - Establishment of Category of Service	X		
1110.1430(b)(4) - Planning Area Need - Service Demand - Expansion of Existing Category of Service		X	
1110.1430(b)(5) - Planning Area Need - Service Accessibility	X		
1110.1430(c)(1) - Unnecessary Duplication of Services	X		
1110.1430(c)(2) - Maldistribution	X		
1110.1430(c)(3) - Impact of Project on Other Area Providers	X		
1110.1430(d)(1) - Deteriorated Facilities			X
1110.1430(d)(2) - Documentation			X
1110.1430(d)(3) - Documentation Related to Cited Problems			X
1110.1430(e) - Staffing Availability	X	X	
1110.1430(f) - Support Services	X	X	X
1110.1430(g) - Minimum Number of Stations	X		
1110.1430(h) - Continuity of Care	X		
1110.1430(j) - Assurances	X	X	X

APPEND DOCUMENTATION AS ATTACHMENT-26, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

4. Projects for relocation of a facility from one location in a planning area to another in the same planning area must address the requirements listed in subsection (a)(1) for the "Establishment of Services or Facilities", as well as the requirements in Section 1110.130 - "Discontinuation" and subsection 1110.1430(i) - "Relocation of Facilities".

The following Sections **DO NOT** need to be addressed by the applicants or co-applicants responsible for funding or guaranteeing the funding of the project if the applicant has a bond rating of A- or better from Fitch's or Standard and Poor's rating agencies, or A3 or better from Moody's (the rating shall be affirmed within the latest 18 month period prior to the submittal of the application):

- Section 1120.120 Availability of Funds – Review Criteria
- Section 1120.130 Financial Viability – Review Criteria
- Section 1120.140 Economic Feasibility – Review Criteria, subsection (a)

VIII. - 1120.120 - Availability of Funds

The applicant shall document that financial resources shall be available and be equal to or exceed the estimated total project cost plus any related project costs by providing evidence of sufficient financial resources from the following sources, as applicable: **Indicate the dollar amount to be provided from the following sources:**

\$1,908,125	a) Cash and Securities – statements (e.g., audited financial statements, letters from financial institutions, board resolutions) as to:
	1) the amount of cash and securities available for the project, including the identification of any security, its value and availability of such funds; and
	2) interest to be earned on depreciation account funds or to be earned on any asset from the date of applicant's submission through project completion;
	b) Pledges – for anticipated pledges, a summary of the anticipated pledges showing anticipated receipts and discounted value, estimated time table of gross receipts and related fundraising expenses, and a discussion of past fundraising experience.
	c) Gifts and Bequests – verification of the dollar amount, identification of any conditions of use, and the estimated time table of receipts;
\$1,586,428 (FMV of Lease)	d) Debt – a statement of the estimated terms and conditions (including the debt time period, variable or permanent interest rates over the debt time period, and the anticipated repayment schedule) for any interim and for the permanent financing proposed to fund the project, including:
	1) For general obligation bonds, proof of passage of the required referendum or evidence that the governmental unit has the authority to issue the bonds and evidence of the dollar amount of the issue, including any discounting anticipated;
	2) For revenue bonds, proof of the feasibility of securing the specified amount and interest rate;
	3) For mortgages, a letter from the prospective lender attesting to the expectation of making the loan in the amount and time indicated, including the anticipated interest rate and any conditions associated with the mortgage, such as, but not limited to, adjustable interest rates, balloon payments, etc.;
	4) For any lease, a copy of the lease, including all the terms and conditions, including any purchase options, any capital improvements to the property and provision of capital equipment;
	5) For any option to lease, a copy of the option, including all terms and conditions.
	e) Governmental Appropriations – a copy of the appropriation Act or ordinance accompanied by a statement of funding availability from an official of the governmental unit. If funds are to be made available from subsequent fiscal years, a copy of a resolution or other action of the governmental unit attesting to this intent;
	f) Grants – a letter from the granting agency as to the availability of funds in terms of the amount and time of receipt;
	g) All Other Funds and Sources – verification of the amount and type of any other funds that will be used for the project.
\$3,494,553	TOTAL FUNDS AVAILABLE

APPEND DOCUMENTATION AS ATTACHMENT-36, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM

IX. 1120.130 - Financial Viability

All the applicants and co-applicants shall be identified, specifying their roles in the project funding or guaranteeing the funding (sole responsibility or shared) and percentage of participation in that funding.

Financial Viability Waiver

The applicant is not required to submit financial viability ratios if:

1. "A" Bond rating or better
2. All of the projects capital expenditures are completely funded through internal sources
3. The applicant's current debt financing or projected debt financing is insured or anticipated to be insured by MBIA (Municipal Bond Insurance Association Inc.) or equivalent
4. The applicant provides a third party surety bond or performance bond letter of credit from an A rated guarantor.

See Section 1120.130 Financial Waiver for information to be provided

APPEND DOCUMENTATION AS ATTACHMENT-37, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

The applicant or co-applicant that is responsible for funding or guaranteeing funding of the project shall provide viability ratios for the latest three years for which audited financial statements are available and for the first full fiscal year at target utilization, but no more than two years following project completion. When the applicant's facility does not have facility specific financial statements and the facility is a member of a health care system that has combined or consolidated financial statements, the system's viability ratios shall be provided. If the health care system includes one or more hospitals, the system's viability ratios shall be evaluated for conformance with the applicable hospital standards.

Provide Data for Projects Classified as:	Category A or Category B (last three years)			Category B (Projected)
Enter Historical and/or Projected Years:				
Current Ratio				
Net Margin Percentage				
Percent Debt to Total Capitalization				
Projected Debt Service Coverage				
Days Cash on Hand				
Cushion Ratio				

Provide the methodology and worksheets utilized in determining the ratios detailing the calculation and applicable line item amounts from the financial statements. Complete a separate table for each co-applicant and provide worksheets for each.

2. Variance

Applicants not in compliance with any of the viability ratios shall document that another organization, public or private, shall assume the legal responsibility to meet the debt obligations should the applicant default.

APPEND DOCUMENTATION AS ATTACHMENT 38, IN NUMERICAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

X. 1120.140 - Economic Feasibility

This section is applicable to all projects subject to Part 1120.

A. Reasonableness of Financing Arrangements

The applicant shall document the reasonableness of financing arrangements by submitting a notarized statement signed by an authorized representative that attests to one of the following:

- 1) That the total estimated project costs and related costs will be funded in total with cash and equivalents, including investment securities, unrestricted funds, received pledge receipts and funded depreciation; or
- 2) That the total estimated project costs and related costs will be funded in total or in part by borrowing because:
 - A) A portion or all of the cash and equivalents must be retained in the balance sheet asset accounts in order to maintain a current ratio of at least 2.0 times for hospitals and 1.5 times for all other facilities; or
 - B) Borrowing is less costly than the liquidation of existing investments, and the existing investments being retained may be converted to cash or used to retire debt within a 60-day period.

B. Conditions of Debt Financing

This criterion is applicable only to projects that involve debt financing. The applicant shall document that the conditions of debt financing are reasonable by submitting a notarized statement signed by an authorized representative that attests to the following, as applicable:

- 1) That the selected form of debt financing for the project will be at the lowest net cost available;
- 2) That the selected form of debt financing will not be at the lowest net cost available, but is more advantageous due to such terms as prepayment privileges, no required mortgage, access to additional indebtedness, term (years), financing costs and other factors;
- 3) That the project involves (in total or in part) the leasing of equipment or facilities and that the expenses incurred with leasing a facility or equipment are less costly than constructing a new facility or purchasing new equipment.

C. Reasonableness of Project and Related Costs

Read the criterion and provide the following:

1. Identify each department or area impacted by the proposed project and provide a cost and square footage allocation for new construction and/or modernization using the following format (insert after this page).

COST AND GROSS SQUARE FEET BY DEPARTMENT OR SERVICE									
Department (list below)	A	B	C	D	E	F	G	H	Total Cost (G + H)
	Cost/Square Foot New	Mod.	Gross Sq. Ft. New	Circ.*	Gross Sq. Ft. Mod.	Circ.*	Const. \$ (A x C)	Mod. \$ (B x E)	
Contingency									
TOTALS									
* Include the percentage (%) of space for circulation									

D. Projected Operating Costs

The applicant shall provide the projected direct annual operating costs (in current dollars per equivalent patient day or unit of service) for the first full fiscal year at target utilization but no more than two years following project completion. Direct cost means the fully allocated costs of salaries, benefits and supplies for the service.

E. Total Effect of the Project on Capital Costs

The applicant shall provide the total projected annual capital costs (in current dollars per equivalent patient day) for the first full fiscal year at target utilization but no more than two years following project completion.

APPEND DOCUMENTATION AS ATTACHMENT -39, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

XI. Safety Net Impact Statement

SAFETY NET IMPACT STATEMENT that describes all of the following must be submitted for **ALL SUBSTANTIVE AND DISCONTINUATION PROJECTS**:

1. The project's material impact, if any, on essential safety net services in the community, to the extent that it is feasible for an applicant to have such knowledge.
2. The project's impact on the ability of another provider or health care system to cross-subsidize safety net services, if reasonably known to the applicant.
3. How the discontinuation of a facility or service might impact the remaining safety net providers in a given community, if reasonably known by the applicant.

Safety Net Impact Statements shall also include all of the following:

1. For the 3 fiscal years prior to the application, a certification describing the amount of charity care provided by the applicant. The amount calculated by hospital applicants shall be in accordance with the reporting requirements for charity care reporting in the Illinois Community Benefits Act. Non-hospital applicants shall report charity care, at cost, in accordance with an appropriate methodology specified by the Board.
2. For the 3 fiscal years prior to the application, a certification of the amount of care provided to Medicaid patients. Hospital and non-hospital applicants shall provide Medicaid information in a manner consistent with the information reported each year to the Illinois Department of Public Health regarding "Inpatients and Outpatients Served by Payor Source" and "Inpatient and Outpatient Net Revenue by Payor Source" as required by the Board under Section 13 of this Act and published in the Annual Hospital Profile.
3. Any information the applicant believes is directly relevant to safety net services, including information regarding teaching, research, and any other service.

A table in the following format must be provided as part of Attachment 43.

Safety Net Information per PA 96-0031			
CHARITY CARE			
Charity (# of patients)	Year	Year	Year
Inpatient			
Outpatient			
Total			
Charity (cost in dollars)			
Inpatient			
Outpatient			
Total			
MEDICAID			
Medicaid (# of patients)	Year	Year	Year
Inpatient			
Outpatient			
Total			

Medicaid (revenue)			
Inpatient			
Outpatient			
Total			

APPEND DOCUMENTATION AS ATTACHMENT-40, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

XII. Charity Care Information

Charity Care information **MUST** be furnished for **ALL** projects.

1. All applicants and co-applicants shall indicate the amount of charity care for the latest three **audited** fiscal years, the cost of charity care and the ratio of that charity care cost to net patient revenue.
2. If the applicant owns or operates one or more facilities, the reporting shall be for each individual facility located in Illinois. If charity care costs are reported on a consolidated basis, the applicant shall provide documentation as to the cost of charity care; the ratio of that charity care to the net patient revenue for the consolidated financial statement; the allocation of charity care costs; and the ratio of charity care cost to net patient revenue for the facility under review.
3. If the applicant is not an existing facility, it shall submit the facility's projected patient mix by payer source, anticipated charity care expense and projected ratio of charity care to net patient revenue by the end of its second year of operation.

Charity care" means care provided by a health care facility for which the provider does not expect to receive payment from the patient or a third-party payer. (20 ILCS 3960/3) Charity Care **must** be provided at cost.

A table in the following format must be provided for all facilities as part of Attachment 44.

CHARITY CARE			
	Year	Year	Year
Net Patient Revenue			
Amount of Charity Care (charges)			
Cost of Charity Care			

APPEND DOCUMENTATION AS ATTACHMENT-41, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

Section I, Identification, General Information, and Certification
Applicants

Certificates of Good Standing for DaVita HealthCare Partners Inc. and Cagles Dialysis, LLC (collectively, the "Applicants") are attached at Attachment – 1. Cagles Dialysis, LLC will be the operator of Chicago Ridge Dialysis. Chicago Ridge Dialysis is a trade name of Cagles Dialysis, LLC and is not separately organized. As the person with final control over the operator, DaVita HealthCare Partners Inc. is named as an applicant for this CON application. DaVita HealthCare Partners Inc. does not do business in the State of Illinois. A Certificate of Good Standing for DaVita HealthCare Partners Inc. from the state of its incorporation, Delaware, is attached.

Delaware

PAGE 1

The First State

I, JEFFREY W. BULLOCK, SECRETARY OF STATE OF THE STATE OF DELAWARE, DO HEREBY CERTIFY "DAVITA HEALTHCARE PARTNERS INC." IS DULY INCORPORATED UNDER THE LAWS OF THE STATE OF DELAWARE AND IS IN GOOD STANDING AND HAS A LEGAL CORPORATE EXISTENCE SO FAR AS THE RECORDS OF THIS OFFICE SHOW, AS OF THE TWELFTH DAY OF DECEMBER, A.D. 2012.

AND I DO HEREBY FURTHER CERTIFY THAT THE SAID "DAVITA HEALTHCARE PARTNERS INC." WAS INCORPORATED ON THE FOURTH DAY OF APRIL, A.D. 1994.

AND I DO HEREBY FURTHER CERTIFY THAT THE FRANCHISE TAXES HAVE BEEN PAID TO DATE.

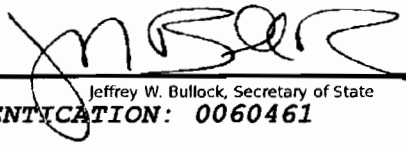
AND I DO HEREBY FURTHER CERTIFY THAT THE ANNUAL REPORTS HAVE BEEN FILED TO DATE.

2391269 8300

121330793

You may verify this certificate online
at corp.delaware.gov/authver.shtml




Jeffrey W. Bullock, Secretary of State
AUTHENTICATION: 0060461

DATE: 12-12-12



To all to whom these Presents Shall Come, Greeting:

I, Jesse White, Secretary of State of the State of Illinois, do hereby certify that

CAGLES DIALYSIS, LLC, A DELAWARE LIMITED LIABILITY COMPANY HAVING OBTAINED ADMISSION TO TRANSACT BUSINESS IN ILLINOIS ON JUNE 24, 2013, APPEARS TO HAVE COMPLIED WITH ALL PROVISIONS OF THE LIMITED LIABILITY COMPANY ACT OF THIS STATE, AND AS OF THIS DATE IS IN GOOD STANDING AS A FOREIGN LIMITED LIABILITY COMPANY ADMITTED TO TRANSACT BUSINESS IN THE STATE OF ILLINOIS.



Authentication #: 1318202452

Authenticate at: <http://www.cyberdriveillinois.com>

In Testimony Whereof, *I hereto set my hand and cause to be affixed the Great Seal of the State of Illinois, this 1ST day of JULY A.D. 2013 .*

Jesse White

SECRETARY OF STATE

Section I, Identification, General Information, and Certification
Site Ownership

The letter of intent between Palestra Real Estate Partners, Inc. and Cagles Dialysis, LLC to lease the facility located at 10511 South Harlem Avenue, Worth, Illinois 60482 is attached at Attachment – 2.



May 1, 2014

Mr. Edgar Levin
USI REAL ESTATE BROKERAGE SERVICES INC.
2215 YORK RD, SUITE 110
OAKBROOK, IL 60523

RE: RESPONSE v8 to Request for Proposal – former Aldi Store Redevelopment
10511 South Harlem Avenue, Worth, IL

Dear Edgar:

Thank you for the Request for Proposal. Below please find our written response to lease the above-referenced Property to be redeveloped by Palestra Real Estate Partners, Inc. or its assigns through the DaVita Preferred Developer Program ("PDP").

DISCLOSURE:

USI Real Estate Brokerage Services Inc. discloses that this Request for Proposal is subject to the terms of Exhibit A attached hereto. The information in this email is confidential and may be legally privileged. It is intended solely for the addressee. Access to this email by anyone else is unauthorized.

PREMISES:

10511 South Harlem Avenue, Worth, IL

LEGAL DESCRIPTION:

See Exhibit C

TENANT (or "Lessee"):

Total Renal Care, Inc. or related entity to be named

LANDLORD (or "Lessor"):

Palestra Real Estate Partners, Inc. or its assigns

SPACE:

Approximately 7,423 contiguous rentable square feet.

PRIMARY TERM & BASE RENT:

Proposed Term and Base Rent is summarized here, and shall be per the Tenant PDP Lease form and the attached Prelim Budget.

Years 1-5: \$172,065.14 per annum (~\$23.18/Rsf)

Years 6-10: \$189,286.50 per annum (~\$25.50/Rsf)

Years 11-15: \$208,215.15 per annum (~\$28.05/Rsf)

ADDITIONAL EXPENSES:

Tenant shall pay additional expenses and additional rent according to the Tenant PDP Lease form. Tenant's pro rata share percentage of the Building shall be 72.14%, which equals 9,638 (total Tenant space) divided by the Building total square feet of 13,360.

LANDLORD'S MAINTENANCE:

Landlord shall be responsible as called for by the Tenant PDP Lease form.

**POSSESSION AND
RENT COMMENCEMENT:**

Landlord shall deliver Possession of the Premises to the Tenant as called for by the Tenant PDP Lease form. Rent Commencement shall be as called for by the Tenant PDP Lease form.

USE:

The Tenant's Use is as called for by the Tenant PDP Lease form. The Tenant's Architect will verify that the Property's Zoning will allow the Tenant's dialysis use. The Tenant's Provisioning Team will determine the postal address it wants.

PARKING:

Preliminarily, from the Site Plan provided by the Seller, it appears the Property contains 87 total parking stalls (a Property ratio of 6.5 per 1000 Rsf). Tenant may have its pro rata share of the Property's parking stalls. Assuming 72.14% and 87, then Tenant may have the unreserved use of 63 parking stalls 6.5 per 1000 Rsf).

BASE BUILDING:

Landlord shall deliver to the Base Building as called for by the Tenant PDP Lease form and by the attached Exhibit B.

TENANT ALLOWANCE:

None.

OPTION TO RENEW:

As called for by the Tenant PDP Lease form.

**RIGHT OF FIRST OPPORTUNITY
ON ADJACENT SPACE:**

Tenant shall have a one-time right of first opportunity, on the adjacent 3,722 Rsf space, such right expiring 12/31/2014. If Tenant leases this space, it shall be under the same terms and conditions of the Tenant PDP Lease form – and made coterminous and thus prorating any other items as necessary to make both Landlord and Tenant whole.

**FAILURE TO DELIVER
PREMISES:**

As called for by the Tenant PDP Lease form.

HOLDING OVER:

As called for by the Tenant PDP Lease form.

TENANT SIGNAGE:

As called for by the Tenant PDP Lease form.

BUILDING HOURS:

As called for by the Tenant PDP Lease form.

SUBLEASE/ASSIGNMENT:

As called for by the Tenant PDP Lease form.

ROOF RIGHTS:

As called for by the Tenant PDP Lease form.

NON COMPETE:

As called for by the Tenant PDP Lease form.

HVAC:

As called for by the Tenant PDP Lease form and attached Exhibit B.

DELIVERIES:

As called for by the Tenant PDP Lease form.

OTHER CONCESSIONS:

As called for by the Tenant PDP Lease form.

**GOVERNMENTAL
COMPLIANCE:**

As called for by the Tenant PDP Lease form.

CONTINGENCIES:

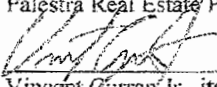
Tenant CON Obligation: Landlord and Tenant understand and agree that the establishment of any chronic outpatient dialysis facility in the State of Illinois is subject to the requirements of the Illinois Health Facilities Planning Act, 20 ILCS 3960/1 et seq. and, thus, the Tenant cannot establish a dialysis facility on the Premises or execute a binding real estate lease in connection therewith unless Tenant obtains a Certificate of Need (CON) permit from the Illinois Health Facilities and Services Review Board (HFSRB). Based on the length of the HFSRB review process, Tenant does not expect to receive a CON permit prior to August 1, 2014. In light of the foregoing facts, the parties agree that they shall promptly proceed with due diligence to negotiate the terms of a definitive lease agreement and execute such agreement prior to approval of the CON permit *provided, however, the lease shall not be binding on either party prior to approval of the CON permit and the lease agreement shall contain a contingency clause indicating that the lease agreement is not effective prior to CON permit approval.* Assuming CON approval is granted, the effective date of the lease agreement shall be the first day of the calendar month following CON permit approval. In the event that the HFSRB does not award Tenant a CON permit to establish a dialysis center on the Premises by August 1, 2014 neither party shall have any further obligation to the other party with regard to the negotiations, lease, or Premises contemplated by this Letter of Intent.

BROKERAGE FEE:

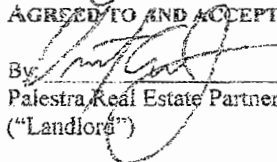
Landlord recognizes USI Real Estate Brokerage Services Inc. as the Tenant's sole representative and shall pay a brokerage fee, per the Tenant PDP, per separate commission agreement.

Thank you for the opportunity to respond to the Request for Proposal.

Sincerely,
Palestra Real Estate Partners, Inc.


Vincent Curran Jr., its President

AGREED TO AND ACCEPTED THIS 12th DAY OF MAY 2014

By: 
Palestra Real Estate Partners, Inc.
("Landlord")

AGREED TO AND ACCEPTED THIS 13th DAY OF MAY 2014

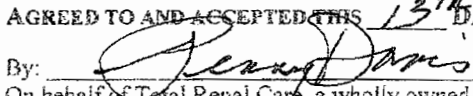
By: 
On behalf of Total Renal Care, a wholly owned subsidiary of
DaVita HealthCare Partners, Inc.
("Tenant")

EXHIBIT A

NON-BINDING NOTICE

NOTICE: THE PROVISIONS CONTAINED IN THIS LETTER OF INTENT ARE AN EXPRESSION OF THE PARTIES' INTEREST ONLY. SAID PROVISIONS TAKEN TOGETHER OR SEPARATELY ARE NEITHER AN OFFER WHICH BY AN "ACCEPTANCE" CAN BECOME A CONTRACT, NOR A CONTRACT. BY ISSUING THIS LETTER OF INTENT NEITHER TENANT NOR LANDLORD (OR USI) SHALL BE BOUND TO ENTER INTO ANY (GOOD FAITH OR OTHERWISE) NEGOTIATIONS OF ANY KIND WHATSOEVER. TENANT RESERVES THE RIGHT TO NEGOTIATE WITH OTHER PARTIES. NEITHER TENANT, LANDLORD OR USI INTENDS ON THE PROVISIONS CONTAINED IN THIS LETTER OF INTENT TO BE BINDING IN ANY MANNER, AS THE ANALYSIS FOR AN ACCEPTABLE TRANSACTION WILL INVOLVE ADDITIONAL MATTERS NOT ADDRESSED IN THIS LETTER, INCLUDING, WITHOUT LIMITATION, THE TERMS OF ANY COMPETING PROJECTS, OVERALL ECONOMIC AND LIABILITY PROVISIONS CONTAINED IN ANY LEASE DOCUMENT AND INTERNAL APPROVAL PROCESSES AND PROCEDURES. THE PARTIES UNDERSTAND AND AGREE THAT A CONTRACT WITH RESPECT TO THE PROVISIONS IN THIS LETTER OF INTENT WILL NOT EXIST UNLESS AND UNTIL THE PARTIES HAVE EXECUTED A FORMAL, WRITTEN LEASE AGREEMENT APPROVED IN WRITING BY THEIR RESPECTIVE COUNSEL. USI IS ACTING SOLELY IN THE CAPACITY OF SOLICITING, PROVIDING AND RECEIVING INFORMATION AND PROPOSALS AND NEGOTIATING THE SAME ON BEHALF OF OUR CLIENTS. UNDER NO CIRCUMSTANCES WHATSOEVER DOES USI HAVE ANY AUTHORITY TO BIND OUR CLIENTS TO ANY ITEM, TERM OR COMBINATION OF TERMS CONTAINED HEREIN. THIS LETTER OF INTENT IS SUBMITTED SUBJECT TO ERRORS, OMISSIONS, CHANGE OF PRICE, RENTAL OR OTHER TERMS; ANY SPECIAL CONDITIONS IMPOSED BY OUR CLIENTS; AND WITHDRAWAL WITHOUT NOTICE. WE RESERVE THE RIGHT TO CONTINUE SIMULTANEOUS NEGOTIATIONS WITH OTHER PARTIES ON BEHALF OF OUR CLIENT. NO PARTY SHALL HAVE ANY LEGAL RIGHTS OR OBLIGATIONS WITH RESPECT TO ANY OTHER PARTY, AND NO PARTY SHOULD TAKE ANY ACTION OR FAIL TO TAKE ANY ACTION IN DETRIMENTAL RELIANCE ON THIS OR ANY OTHER DOCUMENT OR COMMUNICATION UNTIL AND UNLESS A DEFINITIVE WRITTEN LEASE AGREEMENT IS PREPARED AND SIGNED BY TENANT AND LANDLORD.



Exhibit B

MINIMUM BASE BUILDING IMPROVEMENT REQUIREMENTS

[SUBJECT TO MODIFICATION BASED ON INPUT FROM LESSEE'S PROJECT MANAGER WITH RESPECT TO EACH CENTER PROJECT]

At a minimum, the Lessor shall provide the following Base Building Improvements to meet Lessee's requirements for an Existing Base Building Improvements at Lessor's sole cost:

All MBBI work completed by the Lessor will need to be coordinated and approved by the Lessee and there Consultants prior to any work being completed, including shop drawings and submittals reviews.

1.0 - Building Codes & Design

All Minimum Base Building Improvements (MBBI) are to be performed in accordance with all local, state, and federal building codes including any related amendments, fire and life safety codes, ADA regulations, State Department of Public Health, and other applicable and codes as it pertains to Dialysis. All Lessor's work will have Governmental Authorities Having Jurisdiction ("GAHJ") approved architectural and engineering (Mechanical, Plumbing, Electrical, Structural, Civil, Environmental) plans and specifications prepared by a licensed architect and engineer.

Lessee shall have full control over the selection of the General Contractor for the tenant improvement work.

2.0 - Zoning & Permitting

Building and premises must be zoned to perform services as a dialysis clinic. Lessor to provide all Zoning information related to the base building. Any new Zoning changes/variances necessary for use of the premises as a dialysis clinic shall be the responsibility of the Lessee with the assistance of the Lessor to secure Zoning change/variance. Permitting of the interior construction of the space will be by the Lessee.

3.0 - Common Areas

Lessee will have access and use of all common areas i.e. Lobbies Hallways, Corridors, Restrooms, Stairwells, Utility Rooms, Roof Access, Emergency Access Points and Elevators. All common areas must be code and ADA compliant (Life Safety, ADA, etc.) per current federal, state and local code requirements.

4.0 - Demolition

Lessor will be responsible for demolition of all interior partitions, doors and frames, plumbing, electrical, mechanical systems (other than what is designated for reuse by Lessee) and finishes of the existing building from slab to roof deck to create a "Vanilla box" condition. Space shall be broom clean and ready for interior improvements specific to the buildout of a dialysis facility. Building to be free and clear of any components, asbestos or material that is in violation of any EPA standards of acceptance and local hazardous material jurisdiction standards.

5.0 - Foundation and Floor

Existing Foundations and Slab on Grade in Lessee space must be free of cracks and settlement issues. Any cracks and settlement issues evident at any time prior commencement of tenant improvement work shall be subject to inspection by a Licensed Structural Engineer stating that such cracks and / or settlement issues are within limits of the structural integrity and performance anticipated for this concrete and reinforcement design for the term of the lease. Lessor to confirm that the site does not contain expansive soils and to confirm the depth of the water table. Existing concrete slabs shall contain control joints and structural reinforcement.

All repairs will be done by Lessor at his cost and be done prior to Lessee acceptance of space for construction. Any issues with slab during Lessee construction will be brought up to Lessor attention and cost associated with slab issue to repair will be paid by Lessor.

Any slab replacement will be of the same thickness of the adjacent slab (or a minimum of 5") with a minimum concrete strength of 3,000-psi with wire or fiber mesh, and/or rebar reinforcement over vapor barrier and granular fill. Infill slab/trenches will be pinned to existing slab at 24" O.C. with # 4 bars or greater x 16" long or as designed per higher standards by Lessee's structural engineer depending on soils and existing slab condition.

Existing Concrete floor shall not have more than 3-lbs. of moisture per 1,000sf/24 hours is emitted per completed calcium chloride testing results. Means and methods to achieve this level will be sole responsibility of the Lessor.

6.0 - Structural

Existing exterior walls, lintels, floor and roof framing shall remain as-is and be free of defects. Should any defects be found repairs will be made by Lessor at his cost. Any repairs will meet with current codes and approved by a Structural Engineer and Lessee.

Lessor shall supply Lessee (if available) structural engineering drawings of space

7.0 - Existing Exterior Walls

All exterior walls shall be in good shape and properly maintained. Any damaged drywall and or Insulation will be replaced by Lessor prior to Lessee taking possession.

It will be the Lessor's responsibility for all cost to bring exterior walls up to code before Lessee takes possession.

8.0 - Demising walls

New or Existing demising walls shall be a 1 or 2hr fire rated wall depending on local codes, state and or regulatory requirements (NFPA 101 - 2000) whichever is more stringent. If it does not meet this, Lessor will bring demising wall up to meet the ratings/UL requirements. Walls to be fire caulked in accordance with UL standards at floor and roof deck. Demising walls will have sound attenuation batts from floor to underside of deck.

At Lessee's option and as agreed upon by Lessor, any new demising wall interior drywall to lessee's space shall not be installed until after Lessee's improvements are complete in the wall.

9.0- Roof Covering

The roof shall be properly sloped for drainage and flashed for proper water shed. The roof, roof drains and downspouts shall be properly maintained to guard against roof leaks and can properly drain. Lessor will provide Lessee the information on the Roof and Contractor holding warranty. Lessor to provide minimum

of R30 roof insulation at roof deck. If the R30 value is not met, Lessor to increase R-Value by having installed additional insulation to meet GAHJ requirements to the underside of the roof structure/deck.

Any new penetrations made during buildout will be at the Lessee's cost. Lessor shall grant Lessee that right to conceal or remove existing skylights as deemed appropriate by Lessee and their Consultants.

10.0 – Canopy

Lessor shall allow Lessee to design and construct a canopy structure for patient drop off and if allowed local code.

11.0 – Waterproofing and Weatherproofing

Lessor shall provide complete water tight building shell inclusive but not limited to, Flashing and/or sealant around windows, doors, parapet walls, Mechanical / Plumbing / Electrical penetrations. Lessor shall properly seal the building's exterior walls, footings, slabs as required in high moisture conditions such as (including but not limited to) finish floor sub-grade, raised planters, and high water table. Lessor shall be responsible for replacing any damaged items and repairing any deficiencies exposed during / after construction of tenant improvement.

12.0 – Windows

Any single pane window systems must be replaced by Lessor with code compliant Energy efficient thermal pane windows with thermally broken aluminum frames. Broken, missing and/or damaged glass or frames will be replaced by Lessor. Lessor shall allow Lessee, at Lessee's discretion, to tint the existing windows (per manufactures recommendations) per Lessee's tenant improvement design.

13.0 – Thermal Insulation

Lessor to replace any missing and/or damaged wall or ceiling insulation with R-13, 19 or R30 insulation. Any new roof deck insulation is to be installed to the underside of the roof deck.

14.0 – Exterior Doors

All exterior doors shall meet American Disabilities Act (ADA), Local Codes and State Department of Health requirements for egress. If not Lessor at his cost will need to bring them up to code, this will include installing push paddles and/or panic hardware or any other hardware for egress. Any missing weather stripping, damage to doors or frames will be repaired or replaced by Lessor.

Lessor will provide, if not already present, a front entrance and rear door to space. Should one not be present at each of the locations Lessor, to have them installed per the following criteria:

- Front/ Patient Entry Doors: Provide Storefront with insulated glass doors and Aluminum framing to be 42" width including push paddle/panic bar hardware, continuous hinge and lock mechanism. Door to be prepped to accept power assist opener and push button keypad lock provided by Lessee.
- Service Doors: Provide 72" wide double door (Alternates for approval by Lessee's Project Manager to include: 60" Roll up door, or a 48" wide single door or double door with 36" and 24" doors) with 20 gauge insulated hollow metal (double doors), Flush bolts, T astragal, Heavy Duty Aluminum threshold, continuous hinge each leaf, prepped for panic bar hardware (as required by code) painted with rust inhibiting paint and prepped to receive a push button keypad lock provided by Lessee. Door to have a 10" square vision panel cut out with insulated glass installed if requested by Lessee.

Any doors that are designated to be provided modified or prepared by Lessor; Lessor shall provide to Lessee, prior to door fabrication, submittals containing specification information, hardware and shop drawings for review and acceptance by Lessee and Lessee's architect.

15.0 – Utilities

All utilities to be provided at designated utility entrance points into the building at locations approved by the Lessee at a common location for access. Lessor is responsible for all tap/connection and impact fees for all new utilities required for a dialysis facility. All Utilities to be coordinated with Lessee's Architect.

16.0 – Plumbing

Lessor to provide a building water service sized to support Lessee's potable water demand, building fire sprinkler water demand (if applicable), and other tenant water demand (if applicable). Final size to be determined by building potable and sprinkler water combined by means of the total building water demand based on code derived water supply fixture unit method and the building fire sprinkler water hydraulic calculations, per applicable codes and in accordance to municipality and regulatory standards. Lessor to provide a minimum potable water supply to support 30 (60) GPM with a constant 50 PSI water pressure, or as determined by Lessee's Engineer based on Lessee's water demand. Maximum water pressure to Lessee space to not exceed 80 PSI, and where it does water supply to be provided with a pressure reducing valve. Lessor to provide Lessee with a current water flow test results (within current year) indicating pressure and flow, for Lessee's approval.

Where suitable building water already exists, Lessor to provide Lessee with a potable water supply to meet the above minimum requirements. Water flow and pressure to Lessee's space to be unaffected by any other building water requirements such as other tenant water requirements or irrigation systems. Lessor to bring water to Lessee's space, leaving off with a valve and cap for Lessee extension per Lessee direction or Lessee design plans.

Potable water supply to be provided with water meter and two (2) reduced pressure zone (RPZ) backflow devices arranged in parallel for uninterrupted service and sized to support required GPM demand. Backflow devices to be provided with adequate drainage per code and local authority. Meter to be per municipality or water provider standards.

Any existing hose bibs will be in proper working condition prior to Lessee's possession of space.

Building sanitary drain size will be determined by Lessee's Mech Engineer based on total combined drainage fixture units (DFU's) for entire building, but not less than 4 inch diameter. The drain shall be stubbed into the building per location coordinated by Lessee at an elevation no higher than 4 feet below finished floor elevation, to a maximum of 10 feet below finished floor elevation. (Coordinate actual depth and location with Lessee's Architect and Engineer.) Provide with a cleanout structure at building entry point. New sanitary building drain shall be properly pitched to accommodate Lessee's sanitary system design per Lessee's plumbing plans, and per applicable Plumbing Code(s). Lift station/sewage ejectors will not be permitted.

Sanitary drain to be stubbed into Lessee's space with a minimum invert level of 42 inches below finished slab. Sanitary drain to be sized based on the calculated drainage fixture unit (DFU) method in accordance to code for both the Lessee's DFU's combined with any other tenant DFU's sharing the drain however, in no case less than 4 inch diameter. Ejectors or lift stations are prohibited. Lessor to clean, power jet and televiser existing sanitary drain and provide Lessee with a copy of results. Any drains displaying disrepair or improper pitch shall be corrected by Lessor prior to acceptance by Lessee. Where existing conditions are not met, Lessor to provide new sanitary drain to meet such requirements at Lessor's cost and include all relevant Sanitary District and local municipality permit, tap and other fees for such work.

Lessor to provide a plumbing vent no less than 4 inch diameter stubbed into Lessee's space as high as possible with an elevation no less than the bottom of the lowest structural element of the framing to the deck above. Where deck above is the roof, Lessor to provide roof termination and all required roof flashing and waterproofing. Plumbing roof terminations to maintain a minimum separation of 15 feet, or

more if required by local code, from any mechanical rooftop equipment with fresh air intake. Where required separation does not exist, Lessor to relocate to be within compliance at Lessor's cost.

Sanitary sampling manhole if required by local municipality on new line.

Lessor to provide and pay for all tap fees related to new sanitary sewer and water services in accordance with local building and regulatory agencies.

17.0 - Fire Suppression and Alarm System

Fire Sprinkler Systems and building fire alarm control panel shall be maintained by Lessor. Lessor to provide pertinent information on systems for Lessee Engineers for design. Lessor to provide current vendor for system and monitoring company.

Where Sprinkler System is not present and is required by Lessee usage based on local code or NFPA 101, Lessor to provide cost, to be included in lease rate, for the design and installation of a complete turnkey sprinkler system (less drops and heads in lessee space) that meets all local building, fire prevention and life safety codes for the entire building. This system to be on a dedicated water line independent of Lessee's potable water line requirements. Lessor to include all municipal approved shop drawings, service drops and sprinkler heads at heights per Lessee's reflective ceiling plan, flow control switches wired and tested, alarms including wiring and an electrically/telephonically controlled fire alarm control panel connected to a monitoring systems for emergency dispatch.

18.0 - Electrical

Service size to be determined by Lessee's engineer dependant on facility size and gas availability (400amp to 1,000amp service) 120/208 volt, 3 phase, 4 wire derived from a single metered source and consisting of dedicated CT cabinet per utility company standards feeding a distribution panelboard in the Lessee's utility room (location to be per National Electrical Code (NEC) and coordinated with Lessee and their Architect) for Lessee's exclusive use in powering equipment, appliances, lighting, heating, cooling and miscellaneous use. Lessor's service provisions shall include utility metering, tenant service feeder, and distribution panelboard with main and branch circuit breakers. Lessee will not accept multiple services to obtain the necessary capacity. Should this not be available Lessor to upgrade electrical service to meet the following criteria:

Provide new service (preferably underground) with a dedicated meter via a new CT cabinet per utility company standards. Service size to be determined by Lessee's engineer dependant on facility size and gas availability (**preliminary estimate = 1,000 amp service**) 120/208 volt, 3 phase, 4 wire to a distribution panelboard in the Lessee's utility room (location to be per NEC and coordinated with Lessee and their Architect) for Lessee's exclusive use in powering equipment, appliances, lighting, heating, cooling and miscellaneous use. Lessor's service provisions shall include transformer coordination with utility company, transformer pad and grounding, and underground conduit and wire sized for service inclusive of excavation, trenching and restoration, utility metering, distribution panelboard with main and branch circuit breakers, and electrical service and building grounding per NEC.

Lessee's Engineer shall have the final approval on the electrical service size and location and the size and quantity of circuit breakers to be provided in the distribution panelboard. If 480V power is supplied, Lessor to provide step down transformer to Lessee requirements above.

If combined service meter cannot be provided then Lessor shall provide written verification from Power Utility supplier stating multiple meters are allowed for use by the facility for the duration of the lease term.

If lease space is in a multi-tenant building then Lessor to provide meter center with service disconnecting means, service grounding per NEC, dedicated combination CT cabinet with disconnect for Lessee and distribution panelboard per above.

Lessor will allow Lessee to have installed, at Lessee cost, Transfer Switch for temporary generator hook-up, or permanent generator.

Existing electrical raceway, wire, and cable extending through the Lessee's space but serving areas outside the Lessee's space shall be re-routed outside the Lessee's space and reconnected as required at the Lessor's cost.

Fire Alarm system shall be maintained and in good working order by Lessor prior to Lessee acceptance of space. Lessor to provide pertinent information on systems for Lessee's design. Lessor to provide current vendor for system and monitoring company. Lessor's Fire Alarm panel shall include supervision of fire suppression system(s) and connections to emergency dispatch or third party monitoring service in accordance with the local authority having jurisdiction. If lease space is in a multi-tenant building then Lessor to provide an empty conduit stub in Lessee space from Lessor's Fire Alarm panel. If Fire Alarm system is unable to accommodate Lessee requirements and/or FA system is not within applicable code compliance, Lessor to upgrade panel at Lessor's cost.

Fire Alarm system equipment shall be equipped for double detection activation if required.

19.0 - Gas Service

Existing Natural gas service at a minimum to have a 6" water column pressure and be able to supply 800,000-BTU's. Natural gas line shall be individually metered and sized per demand.

20.0 - Mechanical /Heating Ventilation Air Conditioning

Lessor to provide a detailed report from a HVAC company on all existing HVAC units i.e. age, CFM's, cooling capacity, service records etc for review by Lessee. HVAC Units; components and equipment that Lessee intends to reuse shall be left in place 'as is' by Lessor. Lessor shall allow Lessee, at Lessee's discretion to remove, relocate, replace or modify existing unit(s) as needed to meet HVAC code requirements and design layout requirements.

If determined by Lessee that the units need to be replaced and or additional units are needed, Lessor will be responsible for the cost of the replacement/additional HVAC units, Lessee will complete the all work with the replacement/additional HVAC Units. Units replaced or added will meet the design requirements as stated below.

The criteria is as follows:

- Equipment to be Carrier or Trane RTU's
- Supply air shall be provided to the Premises sufficient for cooling and ventilation at the rate of 275 to 325 square feet per ton to meet Lessee's demands for a dialysis facility and the base building Shell loads.
- Ductwork shall be extended 5' into the space for supply and return air.
- System to be a fully ducted return air design
- All ductwork to be externally lined except for the drops from the units.
- Provide 100% enthalpy economizer
- Units to include Power Exhaust
- Controls to be Programmable or DDC
- Provide high efficiency inverter rated non-overloading motors
- Provide 18" curbs, 36" in Northern areas with significant snow fall
- Units to have disconnect and service outlet
- Units will include motorized dampers dampers for OA, RA & EA

- System shall be capable of providing 55deg supply air temperature when it is in the cooling mode

Equipment will be new and come with a full warranty on all parts including compressors (minimum of 5yrs) including labor. Work to include, but not limited to, the purchase of the units, installation, roof framing, mechanical curbs, flashings, gas & electrical hook-up, thermostats and start-up. Anticipate minimum up to five (5) zones with programmable thermostat and or DDC controls (Note: The 5 zones of conditioning may be provided by individual constant volume RTU's, or by a VAV or VVT system of zone control with a single RTU). Lessee's engineer shall have the final approval on the sizes, tonnages, zoning, location and number of HVAC units based on Lessees' design criteria and local and state codes.

21.0 - Telephone

If in a multi tenant building Lessor to provide a 1" conduit from Building Demark location to phone room location in Lessee space.

22.0 - Cable or Satellite TV

Lessee shall have the right to place a satellite dish on the roof and run appropriate electrical cabling from the Premises to such satellite dish and/or install cable service to the Premises at no additional fee. Lessor shall reasonably cooperate and grant "right of access" with Lessee's satellite or cable provider to ensure there is no delay in acquiring such services.

23.0 - Handicap Accessibility

Full compliance with ADA and all local jurisdictions' handicap requirements. Lessor shall comply with all ADA regulations affecting the Building and entrance to Lessee space including, but not limited to, the elevator, exterior and interior doors, concrete curb cuts, ramps and walk approaches to / from the parking lot, parking lot striping for four (4) dedicated handicap stalls for a unit up to 20 station clinic and six (6) HC stalls for units over 20 stations inclusive of pavement markings and stall signs with current local provisions for handicap parking stalls, delivery areas and walkways.

Lessor shall provide pavement marking; curb ramp and accessible path of travel for a dedicated delivery access in the rear of the building. The delivery access shall link the path from the driveway paving to the designated Lessee delivery door and also link to the accessible path of travel.

24.0 - Generator

Lessor to allow a generator to be installed onsite if required by code or Lessee chooses to provide one.

25.0 - Existing Site Lighting

Lessor to provide adequate lighting per code and to illuminate all parking, pathways, for new and existing building access points. Parking lot lighting to be on a timer (and be programmed per Lessee business hours of operation) or photocell. Parking lot lighting shall be connected to and powered by Lessor house panel and equipped. If new lighting is provided it will need to be code compliant with a 90 minute battery back up at all access points.

26.0 - Exterior Building Lighting

Lessor to provide adequate lighting per code and to illuminate the building main and service entrance/exits with related sidewalks. Lighting shall be connected to and powered by Lessor house panel and equipped with a code compliant 90 minute battery back up at all access points.

27.0 – Parking Lot

Provide adequate amount of ADA curb cuts, handicap and standard parking stalls in accordance with dialysis use and overall building uses. Stalls to receive striping, lot to receive traffic directional arrows and concrete parking bumpers. Bumpers to be anchored in place onto the asphalt per stall layout.

28.0 – Refuse Enclosure

If an area is not designated, lessor to provide Refuse area for Lessee dumpsters. Lessor to provide a minimum 6" thick reinforced concrete pad approx 100 to 150SF based and an 8' x 12' apron way to accommodate dumpster and vehicle weight. Enclosure to be provided as required by local codes.

29.0 - Signage

Lessor to allow for an illuminated façade mounted sign and rights to add signage to existing Pylon/monument sign. Final sign layout to be approved by Lessee and the City.

Exhibit C – Legal Description, Tax & Survey Information

Tax Parcel One:

The west 65.80 feet (measured perpendicular to the west line) of Lot 1 in Aldi subdivision, being a subdivision of part of the northwest $\frac{1}{4}$ of Section 18, Township 37 North, Range 13, east of the Third Principal Meridian, according to the Plat thereof recorded June 18, 1990 as document number 90-287592, in Cook County, Illinois.

Tax Parcel Four:

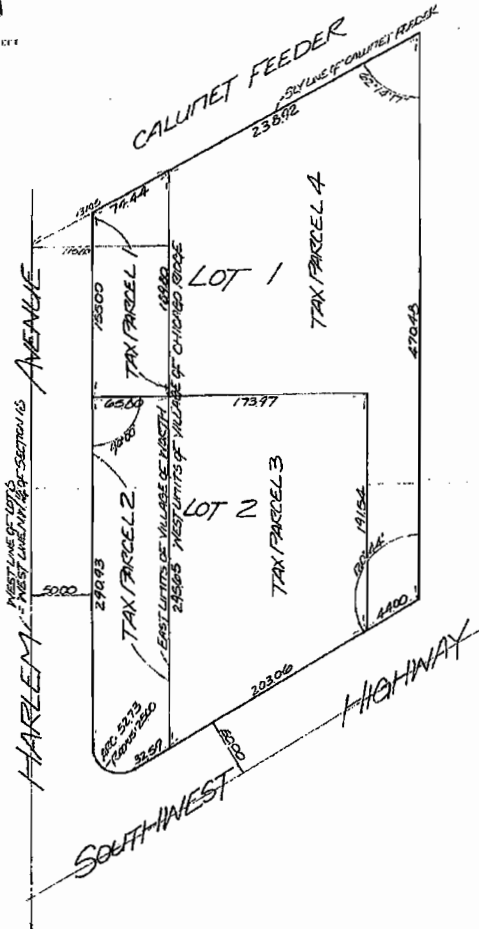
Lot 1 (except the west 65.80 feet measured perpendicular to the west line thereof) in Aldi subdivision being a subdivision of part of the northwest $\frac{1}{4}$ of Section 18, Township 37 North, Range 13, east of the Third Principal Meridian, according to the Plat thereof recorded June 18, 1990 as document number 90-287592, in Cook County, Illinois.

PLAT OF SURVEY

TAX DIVISION MAP

#32

STONELAKE SURVEY CO., LTD.
REGISTERED LAND SURVEYORS
11659 S MAYFIELD AVENUE
WORTH ILLINOIS 60482
PHONE 388-1010



TAX PARCEL ONE: THE WEST 65.80 FEET (MEASURED PERPENDICULAR TO THE WEST LINE) OF LOT 1 IN ALDI SUBDIVISION, BEING A SUBDIVISION OF PART OF THE NORTHWEST 1/4 OF SECTION 18, TOWNSHIP 37 NORTH, RANGE 13, EAST OF THE THIRD PRINCIPAL MERIDIAN, ACCORDING TO THE PLAT THEREOF RECORDED JUNE 16, 1990 AS DOCUMENT NUMBER 98-267592, IN COOK COUNTY, ILLINOIS.

TAX PARCEL TWO: THE WEST 65.80 FEET (MEASURED PERPENDICULAR TO THE WEST LINE) OF LOT 2 IN ALDI SUBDIVISION, BEING A SUBDIVISION OF PART OF THE NORTHWEST 1/4 OF SECTION 18, TOWNSHIP 37 NORTH, RANGE 13, EAST OF THE THIRD PRINCIPAL MERIDIAN, ACCORDING TO THE PLAT THEREOF RECORDED JUNE 16, 1990 AS DOCUMENT NUMBER 98-267592, IN COOK COUNTY, ILLINOIS.

TAX PARCEL THREE: LOT 2 (EXCEPT THE WEST 65.80 FEET, MEASURED PERPENDICULAR TO THE WEST LINE THEREOF) IN ALDI SUBDIVISION, BEING A SUBDIVISION OF PART OF THE NORTHWEST 1/4 OF SECTION 18, TOWNSHIP 37 NORTH, RANGE 13, EAST OF THE THIRD PRINCIPAL MERIDIAN, ACCORDING TO THE PLAT THEREOF RECORDED JUNE 16, 1990 AS DOCUMENT NUMBER 98-267592, IN COOK COUNTY, ILLINOIS.

TAX PARCEL FOUR: LOT 3 (EXCEPT THE WEST 65.80 FEET, MEASURED PERPENDICULAR TO THE WEST LINE THEREOF) IN ALDI SUBDIVISION, BEING A SUBDIVISION OF PART OF THE NORTHWEST 1/4 OF SECTION 18, TOWNSHIP 37 NORTH, RANGE 13, EAST OF THE THIRD PRINCIPAL MERIDIAN, ACCORDING TO THE PLAT THEREOF RECORDED JUNE 16, 1990 AS DOCUMENT NUMBER 98-267592, IN COOK COUNTY, ILLINOIS.

AREAS OF TAX PARCELS

TAX PARCEL ONE - 11,344 SQUARE FEET
TAX PARCEL TWO - 29,305 SQUARE FEET
TAX PARCEL THREE - 42,433 SQUARE FEET
TAX PARCEL FOUR - 50,768 SQUARE FEET

STATE OF ILLINOIS
COUNTY OF COOK

STONELAKE SURVEY CO., LTD. HEREBY CERTIFIES THAT WE HAVE SURVEYED THE ABOVE DESCRIBED PROPERTY AND HAVE PREPARED THE HEREON DRAWN PLAT FOR TAX DIVISION PURPOSES. ALL DIMENSIONS ARE IN FEET AND DECIMAL PARTS THEREOF CORRECTLY AT 42° PERPENDICULAR.

DATED AT WORTH, ILLINOIS THIS 26 DAY OF JUNE, 1990.

STONELAKE SURVEY CO., LTD.

ILLINOIS REGISTERED LAND SURVEYOR #1782

ADDRESS: 7071 EDWELL
SURVEYED FOR: 7071 EDWELL
ORDERED BY: 7071 EDWELL
ORDER NO.: 3004-901

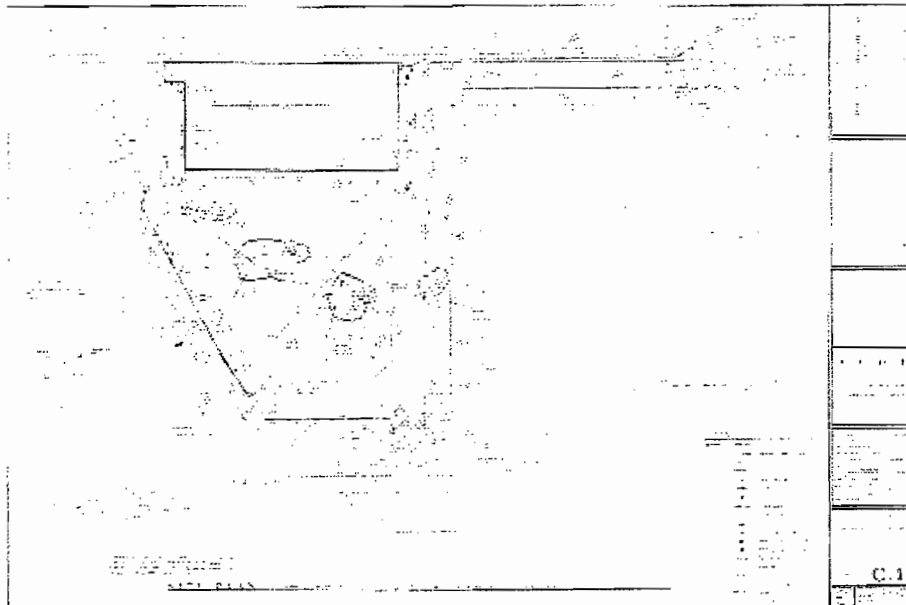
NO MEASUREMENTS ARE TO BE ASSUMED BY SCALE



24181010980000 07/15/2007



24181011000000 07/16/2007



Section I, Identification, General Information, and Certification
Operating Entity/Licensee

The Illinois Certificate of Good Standing for Cagles Dialysis, LLC. is attached at Attachment – 3. The names and percentage ownership of all persons with a five percent or greater ownership in Cagles Dialysis, LLC is listed below.

Name	Address	Ownership Interest
Total Renal Care, Inc.	2000 16 th Street Denver, Colorado 80202	87%
Michael E. Arvan, MD	4542 West 95 th Street Oak Lawn, Illinois 60453	6.5%
Sreya Pallath, MD	4542 West 95 th Street Oak Lawn, Illinois 60453	6.5%



To all to whom these Presents Shall Come, Greeting:

I, Jesse White, Secretary of State of the State of Illinois, do hereby certify that

CAGLES DIALYSIS, LLC, A DELAWARE LIMITED LIABILITY COMPANY HAVING OBTAINED ADMISSION TO TRANSACT BUSINESS IN ILLINOIS ON JUNE 24, 2013, APPEARS TO HAVE COMPLIED WITH ALL PROVISIONS OF THE LIMITED LIABILITY COMPANY ACT OF THIS STATE, AND AS OF THIS DATE IS IN GOOD STANDING AS A FOREIGN LIMITED LIABILITY COMPANY ADMITTED TO TRANSACT BUSINESS IN THE STATE OF ILLINOIS.



Authentication #: 1318202452

Authenticate at: <http://www.cyberdriveillinois.com>

*In Testimony Whereof, I hereto set
my hand and cause to be affixed the Great Seal of
the State of Illinois, this 1ST
day of JULY A.D. 2013*

Jesse White

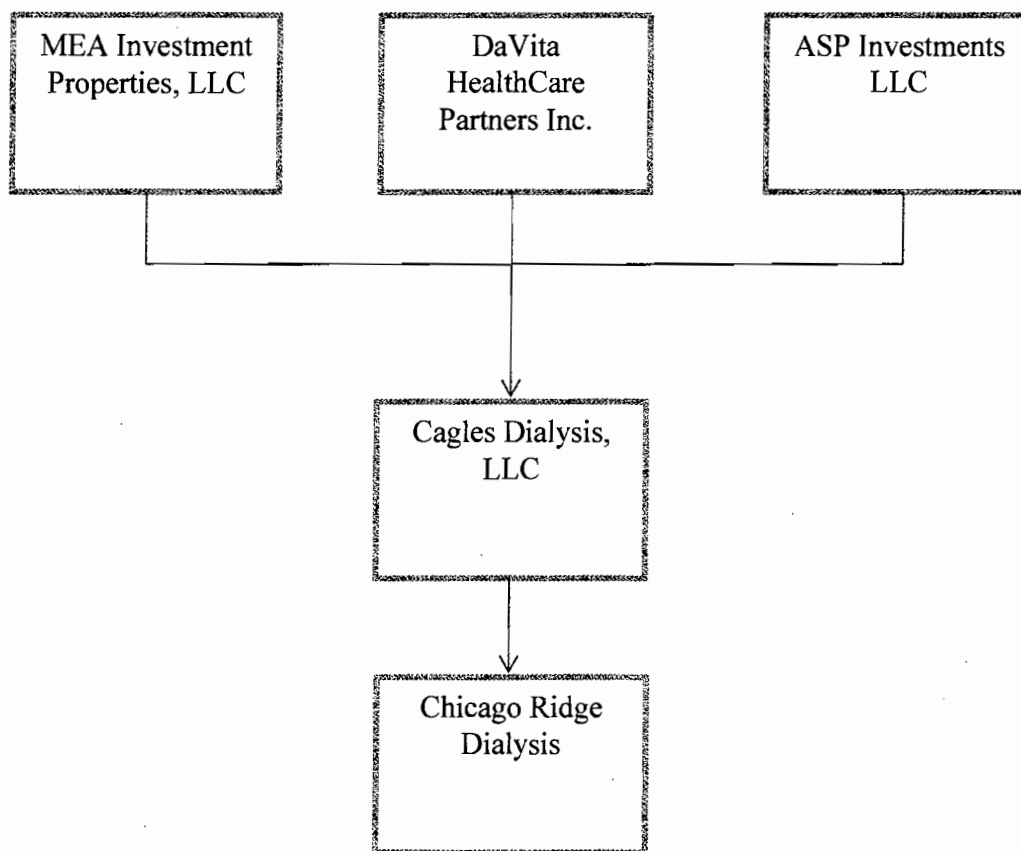
SECRETARY OF STATE

Section I, Identification, General Information, and Certification
Organizational Relationships

The organizational chart for DaVita HealthCare Partners Inc. and Cagles Dialysis, LLC is attached at Attachment – 4.

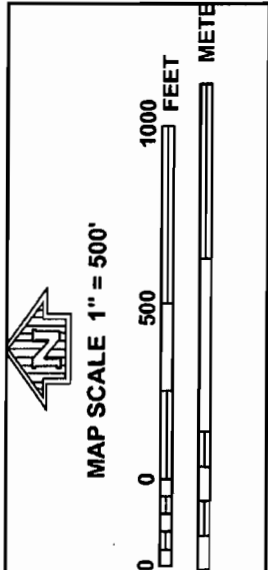
Chicago Ridge Dialysis Center

Organizational Structure



Section I, Identification, General Information, and Certification
Flood Plain Requirements

The site of the proposed dialysis facility complies with the requirements of Illinois Executive Order #2005-5. The proposed dialysis facility will be located at 10511 South Harlem Avenue, Worth, Illinois 60482. As shown on the FEMA flood plain map attached at Attachment – 5, the site of the proposed dialysis facility is located outside of a flood plain.



NFP PANEL 0608J

FIRM
FLOOD INSURANCE RATE MAP
COOK COUNTY,
ILLINOIS
AND INCORPORATED AREAS

PANEL 608 OF 832
 (SEE MAP INDEX FOR FIRM PANEL LAYOUT)

CONTAINS:

COMMUNITY	NUMBER	PANEL	SUFFIX
BROOKVIEW VILLAGE OF	170065	0608	J
CHICAGO RIDGE, VILLAGE OF	170076	0608	J
COOK COUNTY	170054	0608	J
HICKORY HILLS, CITY OF	170103	0608	J
OAK LAWN, VILLAGE OF	170137	0608	J
PALOS HILLS, CITY OF	170143	0608	J
WORTH, VILLAGE OF	170177	0608	J

Notice to User: The Map Number shown below should be used for all insurance applications for the subject community.

MAP NUMBER
17031C0608J
MAP REVISED
AUGUST 19, 2008



Federal Emergency Management Agency

NATIONAL FLOOD INSURANCE PROGRAM

This is an official copy of a portion of the above referenced flood map. It was extracted using F-MIT CH-Line. This map does not reflect changes or amendments which may have been made subsequent to the date on the title block. For the latest product information about National Flood Insurance Program flood maps check the FEMA Flood Map Store at www.msc.fema.gov



Section I, Identification, General Information, and Certification
Historic Resources Preservation Act Requirements

The Historic Preservation Act determination from the Illinois Historic Preservation Agency is attached at Attachment – 6.



**Illinois Historic
Preservation Agency**

FAX (217) 782-8161

1 Old State Capitol Plaza • Springfield, Illinois 62701-1512 • www.illinois-history.gov

Cook County
Worth

CON - Establish a 16-Station Dialysis Facility
10511 S. Harlem Ave.
IHPA Log #005080213

August 13, 2013

Timothy Tincknell
DaVita Healthcare Partners, Inc.
2611 N. Halsted St.
Chicago, IL 60614

Dear Mr. Tincknell:

This letter is to inform you that we have reviewed the information provided concerning the referenced project.

Our review of the records indicates that no historic, architectural or archaeological sites exist within the project area.

Please retain this letter in your files as evidence of compliance with Section 4 of the Illinois State Agency Historic Resources Preservation Act (20 ILCS 3420/1 et. seq.). This clearance remains in effect for two years from date of issuance. It does not pertain to any discovery during construction, nor is it a clearance for purposes of the Illinois Human Skeletal Remains Protection Act (20 ILCS 3440).

If you have any further questions, please contact me at 217/785-5027.

Sincerely,

Anne E. Haaker

Anne E. Haaker
Deputy State Historic
Preservation Officer

Section I, Identification, General Information, and Certification
Project Costs and Sources of Funds

Table 1120.110			
Project Cost	Clinical	Non-Clinical	Total
Modernization Contracts	\$1,025,000		\$1,025,000
Contingencies	\$148,625		\$148,625
Architectural/Engineering Fees	\$86,000		\$86,000
Consulting and Other Fees	\$53,500		\$53,500
Moveable and Other Equipment			
Communications	\$89,730		\$89,730
Water Treatment	\$127,391		\$127,391
Bio-Medical Equipment	\$9,964		\$9,964
Clinical Equipment	\$283,357		\$283,357
Clinical Furniture/Fixtures	\$21,878		\$21,878
Lounge Furniture/Fixtures	\$3,157		\$3,157
Storage Furniture/Fixtures	\$6,013		\$6,013
Business Office Fixtures	\$14,870		\$14,870
General Furniture/Fixtures	\$26,304		\$26,304
Signage	\$12,336		\$12,336
Total Moveable and Other Equipment	\$595,000		\$595,000
Fair Market Value of Leased Space	\$1,586,428		\$1,586,428
Total Project Costs	\$3,494,553		\$3,494,553

Section I, Identification, General Information, and Certification
Project Status and Completion Schedules

The Applicants anticipate project completion within 18 months of project approval. Specifically, the timeline is as follows:

- 3 months for Schematics Design
- 6 months for Construction
- 3 months for Permit Approval
- 6 months for Completion of Medicare Enrollment

Further, although the Letter of Intent attached at Attachment – 2 provides for project obligation to occur after permit issuance, the Applicants will begin negotiations on a definitive lease agreement for the facility, with the intent of project obligation being contingent upon permit issuance.

Section I, Identification, General Information, and Certification
Cost Space Requirements

Cost Space Table							
Dept. / Area	Cost	Gross Square Feet		Amount of Proposed Total Gross Square Feet That Is:			
		Existing	Proposed	New Const.	Modernized	As Is	Vacated Space
CLINICAL							
ESRD	\$3,494,553		7,423		7,423		
Total Clinical	\$3,494,553		7,423		7,423		
NON REVIEWABLE							
Total Non-Reviewable							
TOTAL	\$3,494,553		7,423		7,423		

Section III, Project Purpose, Background and Alternatives – Information Requirements
Criterion 1110.230(a), Project Purpose, Background and Alternatives

Background of the Applicant

The Applicants are fit, willing and able, and have the qualifications, background and character to adequately provide a proper standard of health care services for the community. For this project, DaVita HealthCare Partners Inc. has partnered with Cagles Dialysis, LLC in their commitment to the Chicago Ridge community. The proposed project involves the establishment of a 16-station dialysis facility to be located at 15011 South Harlem Avenue, Worth, Illinois 60482.

DaVita HealthCare Partners Inc is a leading provider of dialysis services in the United States and is committed to innovation, improving clinical outcomes, compassionate care, education and empowering patients, and community outreach. A copy of DaVita's 2012 Community Care report, some of which is outlined below, details DaVita's commitment to quality, patient centric focus and community outreach, was previously submitted on April 24, 2014 as part of the Applicants' application for Proj. No. 14-016.

DaVita has taken on many initiatives to improve the lives of patients suffering from chronic kidney disease ("CKD") and end stage renal disease ("ESRD"). These programs include the Kidney Smart, IMPACT, CathAway, and transplant assistance programs. Information on the Kidney Smart, IMPACT and CathAway programs, in addition to six press releases: "DaVita HealthCare Partners Celebrates Milestones of 2013," "DaVita's Approach to Integrated Care Nationally Recognized," "DaVita's Teammate-Focused Culture Gains National and Local Awards," "FORTUNE Magazine Names DaVita Among Most Admired Companies for Ninth Consecutive Year," "DaVita Gives \$1.2 Million to Nonprofits Across the US," and "DaVita Delivers First-of-its-Kind Dialysis Treatment in the U.S." are attached at Attachment – 11A.

There are over 26 million patients with CKD and that number is expected to rise. Current data reveals troubling trends, which help explain the growing need for dialysis services:

- Between 1988-1994 and 2005-2010, the overall prevalence estimate for CKD rose from 12.3 to 14.0 percent. The largest relative increase, from 25.4 to 40.8 percent, was seen in those with cardiovascular disease.¹
- Many studies have shown that diabetes, hypertension, cardiovascular disease, higher body mass index, and advancing age are associated with the increasing prevalence of CKD.²
- Nearly six times the number of new patients began treatment for ESRD in 2011 (approximately 116,000) versus 1980 (approximately 20,000).³
- Nearly eleven times more patients are now being treated for ESRD than in 1980 (approximately 615,000 versus approximately 60,000).⁴
- U.S. patients newly diagnosed with ESRD were 1 in 2,800 in 2011 versus 1 in 11,000 in 1980.⁵
- U.S. patients treated for ESRD were 1 in 526 in 2011 versus 1 in 3,400 in 1980.⁶

¹ US Renal Data System, USRDS 2013 Annual Data Report: Atlas of Chronic Kidney Disease and End-Stage Renal Disease in the United States, National Institutes of Health, National Institute of Diabetes and Digestive and Kidney Diseases, Bethesda, MD, 44 (2013).

² Id. at 46

³ Id. at 158

⁴ Id.

⁵ Id. at 160

⁶ Id.

- Increasing prevalence in the diagnosis of diabetes and hypertension, the two major causes of CKD; 44% of new ESRD cases have a primary diagnosis of diabetes; 28% have a primary diagnosis of hypertension.⁷
- Nephrology care prior to ESRD continues to be a concern. Since the 2005 introduction of the new Medical Evidence form (2728), with fields addressing pre-ESRD care, there has been little progress made in this area (pre-ESRD data, however, should be interpreted with caution because of the potential for misreporting). Forty-two percent of new ESRD patients in 2011, for example, had not seen a nephrologist prior to beginning therapy. And among these patients, 51 percent of those on hemodialysis began therapy with a catheter, compared to 19 percent of those who had received a year or more of nephrology care. Among those with a year or more of pre-ESRD nephrologist care, 30 percent began therapy with a fistula – five times higher than the rate among non-referred patients.⁸

Additionally, DaVita's Kidney Smart program helps to improve intervention and education for pre-ESRD patients. Approximately 65-75% of CKD Medicare patients have never been evaluated by a nephrologist.⁹ Timely CKD care is imperative for patient morbidity and mortality. Adverse outcomes of CKD can often be prevented or delayed through early detection and treatment. Several studies have shown that early detection, intervention and care of CKD may result in improved patient outcomes and reduce ESRD:

- Reduced GFR is an independent risk factor for morbidity and mortality,
- A reduction in the rate of decline in kidney function upon nephrologists referrals has been associated with prolonged survival of CKD patients,
- Late referral to a nephrologist has been correlated with lower survival during the first 90 days of dialysis, and
- Timely referral of CKD patients to a multidisciplinary clinical team may improve outcomes and reduce cost.

A care plan for patients with CKD includes strategies to slow the loss of kidney function, manage comorbidities, and prevent or treat cardiovascular disease and other complications of CKD, as well as ease the transition to kidney replacement therapy. Through the Kidney Smart program, DaVita offers educational services to CKD patients that can help patients reduce, delay, and prevent adverse outcomes of untreated CKD. DaVita's Kidney Smart program encourages CKD patients to take control of their health and make informed decisions about their dialysis care.

To extend DaVita's CKD education and awareness programs to the Spanish-speaking population, DaVita launched its Spanish-language website (DaVita.com/Espanol) in November 2011. Similar to DaVita's English-language website, DaVita.com/Espanol provides easy-to-access information for Spanish-speaking kidney care patients and their families, including educational information on kidney disease, treatment options, and recipes.

DaVita's IMPACT program seeks to reduce patient mortality rates during the first 90-days of dialysis through patient intake, education and management, and reporting. In fact, since piloting in October 2007, the program has not only shown to reduce mortality rates by 8 percent but has also resulted in improved patient outcomes.

⁷ Id at 161

⁸ Id. at 216-217

⁹ US Renal Data System, USRDS 2011 Annual Data Report: Atlas of Chronic Kidney Disease and End-Stage Renal Disease in the United States, Bethesda, MD: National Institutes of Health, National Institute of Diabetes and Digestive and Kidney Diseases; 2011.

DaVita's CathAway program seeks to reduce the number of patients with central venous catheters ("CVC"). Instead patients receive arteriovenous fistula ("AV fistula") placement. AV fistulas have superior patency, lower complication rates, improved adequacy, lower cost to the healthcare system, and decreased risk of patient mortality compared to CVCs. In July 2003, the Centers for Medicare and Medicaid Services, the End Stage Renal Disease Networks and key providers jointly recommended adoption of a National Vascular Access Improvement Initiative ("NVAII") to increase the appropriate use of AV fistulas for hemodialysis. The CathAway program is designed to comply with NVAII through patient education outlining the benefits for AV fistula placement and support through vessel mapping, fistula surgery and maturation, first cannulation and catheter removal. Since the inception of the program, DaVita has achieved a 45 percent reduction in the number of "Day 90+" catheter patients. As of November 2013, DaVita's catheter use rate is at an all-time low with 13 percent of patients dialyzing at DaVita for 90 days or more with a catheter in place. DaVita is an industry leader in the rate of fistula use and has the lowest day-90 catheter rates among large dialysis providers.

In an effort to improve patient outcomes and experience during dialysis, on May 13, 2014, DaVita announced the first delivery of hemodiafiltration in the United States. It is delivering hemodiafiltration treatments to select patients at its North Colorado Springs Clinic as part of a six-month trial program. Hemodiafiltration incorporates the standard hemodialysis process but adds an extra step to remove even larger toxin particles. It is commonly practiced in Europe but until recently there was no FDA approved device for use in the U.S. Over the next six months, DaVita clinical experts will determine whether there are improved outcomes of dialysis treatment and patient quality of life compared to hemodialysis.

For more than a decade, DaVita has been investing and growing its integrated kidney care capabilities, and on May 5, 2014, DaVita's approach to integrated care was recognized with two Dorland Health "Case in Point" Platinum Awards for its Pathways Care Management and VillageHealth Integrated Care Management programs. The Dorland Health awards recognize the most successful and innovative case-management programs working to improve health care across the continuum.

Through Patient Pathways, DaVita partners with hospitals to provide faster, more accurate ESRD patient placement to reduce the length of hospital inpatient stays and readmissions. Importantly, Patient Pathways is not an intake program. An unbiased onsite liaison, who specializes in ESRD patient care, meets with both newly diagnosed and existing ESRD patients to assess their current ESRD care and provide information about insurance, treatment modalities, outpatient care, financial obligations before discharge, and grants available to ESRD patients. Patients choose a provider/center that best meets their needs for insurance, preferred nephrologists, transportation, modality and treatment schedule.

DaVita currently partners with over 350 hospitals nationwide through Patient Pathways. Patient Pathways has demonstrated benefits to hospitals, patients, physicians and dialysis centers. Since the pilot launch in 2010 and the subsequent program launch in 2013, Patient Pathways has impacted over 5,000 patients and reduced hospital readmission rates an average of 27 percent, saving hospital partners more than \$11 million. Moreover, patients are better educated and arrive at the dialysis center more prepared and less stressed. They have a better understanding of their insurance coverage and are more engaged and satisfied with their choice of dialysis facility. As a result, patients have higher attendance rates, are more compliant with their dialysis care, and have fewer avoidable readmissions.

Since 1996, Village Health has innovated to become the country's largest renal National Committee for Quality Assurance accredited disease management program. VillageHealth's Integrated Care Management ("ICM") services partners with patients, providers and care team members to focus on the root causes of unnecessary hospitalizations such as unplanned dialysis starts, infection, fluid overload and medication management.

VillageHealth ICM services for payers and ACOs provide CKD and ESRD population health management delivered by a team of dedicated and highly skilled nurses who support patients both in the field and on the phone. Nurses use VillageHealth's industry-leading renal decision support and risk stratification software to manage a patient's coordinated needs. Improved clinical outcomes and reduced hospital readmission rates have contributed to improved quality of life for patients. VillageHealth ICM has

delivered up to a 15 percent reduction in non-dialysis medical costs for ESRD patients. Applied to DaVita's managed ESRD population, this represents an annual savings of more than \$30 million.

DaVita's transplant referral and tracking program ensures every dialysis patient is informed of transplant as a modality option and promotes access to transplantation for every patient who is interested and eligible for transplant. The social worker or designee obtains transplant center guidelines and criteria for selection of appropriate candidates and assists transplant candidates with factors that may affect their eligibility, such as severe obesity, adherence to prescribed medicine or therapy, and social/emotional/financial factors related to post-transplant functioning.

In an effort to better serve all kidney patients, DaVita believes in requiring that all providers measure outcomes in the same way and report them in a timely and accurate basis or be subject to penalty. There are four key measures that are the most common indicators of quality care for dialysis providers - dialysis adequacy, fistula use rate, nutrition and bone and mineral metabolism. Adherence to these standard measures has been directly linked to 15-20% fewer hospitalizations. On each of these measures, DaVita has demonstrated superior clinical outcomes, which directly translated into 7% reduction in hospitalizations among DaVita patients, the monetary result of which is more than \$1.5 billion in savings to the health care system and the American taxpayer since 2010.

DaVita Rx, the first and largest licensed, full-service U.S. renal pharmacy, focuses on the unique needs of dialysis patients. Since 2005, DaVita Rx has been helping improve outcomes by delivering medications to dialysis centers or to patients' homes, making it easier for patients to keep up with their drug regimens. As of 2012, DaVita Rx patients have an 82% adherence rate, compared to those who use chain pharmacies and have a 32% adherence rate, and those who use independent pharmacies and have a 36% adherence rate. In addition, better adherence may lead to fewer hospitalizations for patients using DaVita Rx versus those patients not on this service. Hospitalizations (per member per 1000) was 1.4 for Non-DaVita Rx patients versus 1.0 for DaVita Rx patients in 2012.

DaVita has been repeatedly recognized for its commitment to its employees (or teammates), particularly its more than 1,700 teammates who are reservists, members of the National Guard, military veterans, and military spouses. In June 2013, DaVita received the prestigious Secretary of Defense Employer Support Freedom Award. Presented annually by the Employer Support of the Guard and Reserve ("ESGR"), an arm of the Department of Defense, the Freedom Award recognizes employers for outstanding support of employees who serve in the Guard and Reserve. It is the highest military-friendly award presented by the U.S. government. Nearly 3,000 employers were nominated for a Freedom Award in 2013. An awards committee composed of senior Department of Defense officials, business leaders and prior honorees selected just 15 companies to receive the 2013 Freedom Award. DaVita also received the 2013 award for Best Military Recruiting Program from ERE Media and was recognized this year with Top 100 Military Friendly Employer and 2013 Top 100 Military Friendly Spouse Employer awards from GI Jobs, a Most Valuable Employers award from CivilianJobs.com and a "Best for Vets" award from Military Times EDGE.

In April 2014, DaVita received three major national and local awards for its focus on its teammates: WorldBlu Most Democratic Workplaces, Top Workplaces Colorado and LearningElite Silver. For the seventh consecutive year, DaVita appeared on WorldBlu's list of most democratic work places. WorldBlu surveys organizations' teammates to determine the level of democracy practiced. For the third consecutive year, WorkplaceDynamics also recognized DaVita as one of the top workplaces in Colorado, based on employee input. DaVita was named a Silver LearningElite organization for 2014 by *Chief Learning Officer* magazine for creating and implementing exemplary teammate development practices that deliver measurable business value. DaVita ranked No. 29 in a record breaking field of more than 200 companies. Finally, DaVita has been recognized as a one of *Fortune*® Magazine's Most Admired Companies in 2014. DaVita ranked first overall among health care facilities and was the second highest-rated company in Colorado.

DaVita is also committed to sustainability and reducing its carbon footprint. In fact, it is the only kidney care company recognized by the Environmental Protection Agency for its sustainability initiatives. In 2010, DaVita opened the first LEED-certified dialysis center in the U.S. Furthermore, it annually saves

approximately 8 million pounds of medical waste through dialyzer reuse and it also diverts more than 85% of its waste through composting and recycling programs. It has also undertaken a number of similar initiatives at its offices and is seeking LEED Gold certification for its corporate headquarters. In addition, DaVita was also recognized as an "EPA Green Power Partner" by the U.S. Environmental Protection Agency.

DaVita consistently raises awareness of community needs and makes cash contributions to organizations aimed at improving access to kidney care. DaVita provides significant funding to kidney disease-awareness organizations such as the Kidney TRUST, the National Kidney Foundation, the American Kidney Fund, and several other organizations. Its own employees, or members of the "DaVita Village," assisted in these initiatives and have raised approximately \$5 million, thus far, through the annual Tour DaVita bicycle ride, with \$1 million coming in 2013 alone. The Kidney Rock 5K Run/Walk raised an estimated \$1 million for Bridge of Life – DaVita Medical Missions in 2011 and 2012, combined. DaVita continued its "DaVita Way of Giving" program in 2013 with teammates at clinics across DaVita's 43-state footprint selecting more than 1100 charities from Ronald McDonald House to small community-support entities in their local areas, to receive approximately \$1.2 million in contributions.

DaVita does not limit its community engagement to the U.S. alone. It founded Bridge of Life, a 501(c)(3) nonprofit organization that operates on donations to bring care to those for whom it is out of reach. In 2013, nearly 50 volunteers from Bridge of Life- DaVita Medical Missions™ worked to complete 15 missions in 11 countries, during which volunteers and partners helped to install or repair 77 dialysis machines and train more than 50 kidney care professionals, bringing treatment and quality care to an addition 420 people around the world.

1. Neither the Centers for Medicare and Medicaid Services nor the Illinois Department of Public Health has taken any adverse action involving civil monetary penalties or restriction or termination of participation in the Medicare or Medicaid programs against any of the applicants, or against any Illinois health care facilities owned or operated by the Applicants, directly or indirectly, within three years preceding the filing of this application. Health care facilities owned or operated by the Applicants:

A list of health care facilities owned or operated by the Applicants in Illinois is attached at Attachment – 11B.

Dialysis facilities are currently not subject to State Licensure in Illinois.

2. Certification that no adverse action has been taken against either of the Applicants or against any health care facilities owned or operated by the Applicants in Illinois within three years preceding the filing of this application is attached at Attachment – 11C.
3. An authorization permitting the Illinois Health Facilities and Services Review Board ("HFSRB") and the Illinois Department of Public Health ("IDPH") access to any documents necessary to verify information submitted, including, but not limited to: official records of IDPH or other State agencies; and the records of nationally recognized accreditation organizations is attached at Attachment – 11C.



600 Highway Street, 8th Floor, San Francisco, CA 94104 | 1-800-368-4877 | www.davita.com

Office of the Chief
Medical Officer (OCMO)
Allen R. Nissenson, MD
Chief Medical Officer
Meredith Mathews, MD
Robert Provenzano, MD
John Robertson, MD
David B. Van Wyck, MD

April 30, 2009

Dear Medical Directors:

As your partner, DaVita® and OCMO are committed to helping you achieve unprecedented clinical outcomes with your patients. As part of OCMO's Relentless Pursuit of Quality™, DaVita will be launching our top two clinical initiatives; IMPACT, and CathAway™ at our annual 2009 Nationwide Meeting. Your facility administrators will be orienting you on both programs upon their return from the meeting in early May.



IMPACT: The goal of IMPACT is to reduce incident patient mortality. IMPACT stands for Incident Management of Patients Actions Centered on Treatment. The program focuses on three components: patient intake, education and management and reporting. IMPACT has been piloting since October 2007 and has demonstrated a reduction in mortality. The study recently presented at the National Kidney Foundation's Spring Clinical Meeting in Nashville, TN. In addition to lower mortality rates, patient outcomes improved - confirming this vulnerable patient population is healthier under DaVita's relentless pursuit of quality care.



CathAway: Higher catheter use is associated with increased infection, morbidity, mortality and hospitalizations ⁽¹⁾⁽²⁾. The 7-step Cathaway Program supports reducing the number of patients with central venous catheters (CVCs). The program begins with patient education outlining the benefits of fistula placement. The remaining steps support the patient through vessel mapping, fistula surgery and maturation, first cannulation and catheter removal. For general information about the CathAway program, see the November 2008 issue of QUEST, DaVita's Nephrology Journal.

As Medical Directors, here is how you can support both initiatives in your facilities:

- **Assess incident patients regularly in their first 90 days:** At your monthly DaVita QIFMM meetings, discuss patients individually and regularly. Use the IMPACT scorecard to prompt these discussions.
- **Adopt "Facility Specific Orders":** Create new facility specific orders using the form that will be provided to you. Each of your attending physicians will also need to be educated on the use of the form for their new patients.
- **Minimize the "catheter-removal" cycle time:** At your monthly DaVita QIFMM meetings, review each of your catheter patients with the team and identify obstacles causing delays in catheter removal.
- **Plan fistula and graft placements:** Start AV placement plans early by scheduling vessel mapping and surgery evaluation appointments for Stage 4 CKD patients. Schedule fistula placement surgery for those patients where ESRD is imminent in the next 3-6 months. Share early fistula and graft placement expectations with attending physicians in your dialysis facilities.

Strong. Smarter. Together. Focus. That's how we get it right. www.davita.com

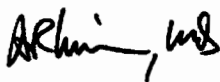
DaVita.

Launch Kits:

In May, Launch Kits containing materials and tools to support both initiatives will be arriving at your facilities. IMPACT kits will include a physician introduction to the program, step by step implementation plan and a full set of educational resources. FAs and Vascular Access Leaders will begin training on a new tool to help identify root-causes for catheter removal delays.

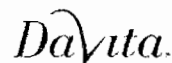
As the leader in the dialysis center, your support of these efforts is crucial. As always, I welcome your feedback, questions and ideas. Together with you, our physician partners, we will drive catheter use to all-time lows and help give our incident patients the quality and length of life they deserve.


Sincerely,



Allen R. Nissenson, MD, FACP
Chief Medical Officer, DaVita

- (1) Dialysis Outcomes and Practice Patterns Study (DOPPS): 2 yrs/7 Countries / 10,000 pts.
- (2) Pastan et al: Vascular access and increased risk of death among hemodialysis patients.




**Kidney Smart**

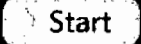
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Welcome

Kidney SmartSM Education Program
Your comprehensive guide to Chronic Kidney Disease (CKD)

 **Introduction**
Play Video

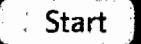
I am in the **Early Stage of CKD**


 **Start**

 **Not sure?**
Play Section Guide

Few or no symptoms
Not on dialysis
CKD Stage 1, 2 or 3

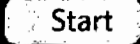
I am in the **Late Stage of CKD**


 **Start**

 **Not sure?**
Play Section Guide

Considering or on dialysis
Considering transplant
GFR <30, CKD Stage 4 or 5

I am a **Care Partner**

 **Start**

 **Not sure?**
Play Section Guide

Family and friends of people with chronic kidney disease



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Content Guide

I am in the Early Stage of CKD

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Choices

- [Take Control](#)
- [Make a Plan - Diet and Exercise](#)
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- [Stay Your Course](#)

I am in the Late Stage of CKD

Living

- [What Do Diagnosis and Treatment Mean for Me?](#)
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- [Make a Plan - Home Hemodialysis](#)
- [Make a Plan - Palliative Care/Conservative Choice](#)
- [Stay Your Course](#)

I am a Care Partner

Caring for Someone with CKD

- [Being an Effective Care Partner](#)
- [Support for Home Hemodialysis](#)
- [Support for Home Peritoneal Dialysis](#)
- [Support for Post-Transplant](#)

Caring for Yourself

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- [Recognize Burnout](#)

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Kidney Smart was produced by a multi-disciplinary team of healthcare providers and health education professionals who are teammates of DaVita, Inc.
The content presented here is intended to be informational only, and does not replace the advice of your doctor.

I Have Early-Stage
Kidney Disease

I Have Late-Stage
Kidney Disease



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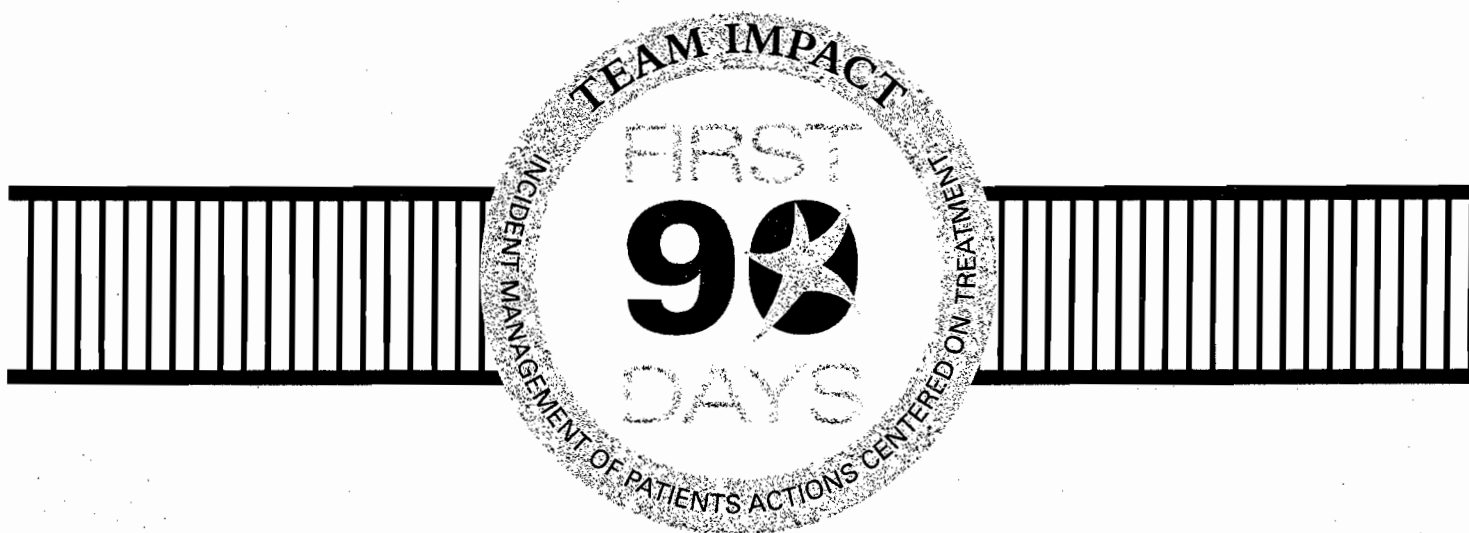
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Please check with a physician if you need a diagnosis and/or for treatments as well as information regarding your specific condition. If you are experiencing urgent medical conditions, call 9-1-1



Davita®



Dear Physician Partners:

IMPACT™ is an initiative focused on reducing incident patient mortality. The program provides a comprehensive onboarding process for incident patients, with program materials centered on four key clinical indicators—access, albumin, anemia, and adequacy.

Medical Directors: How can you support IMPACT in your facilities?

- Customize the new Standard Admission Order template into facility-specific orders. Drive use of the standard order with your attending physicians
- Review your facility IMPACT scorecard at your monthly QIFMM meeting
- Talk about IMPACT regularly with your attending physicians

Attending Physicians: How can you support IMPACT in your facilities?

- Use the IMPACT scorecard to assess incident patients
- Educate teammates about the risk incident patients face and how IMPACT can help

How was IMPACT developed? What are the initial results?

From October 2007 to April 2009, IMPACT was piloted in DaVita® centers. Early results, presented at the National Kidney Foundation's Spring Clinical Meeting in Nashville, TN this April, showed an 8% reduction in annualized mortality. In addition to lower mortality, IMPACT patients showed improvements in fistula placement rates and serum albumin levels. The results are so impressive that we are implementing this program throughout the Village.

Your support of this effort is crucial.

If you have not seen the IMPACT order template and scorecard by the end of June, or if you have additional questions about the program, email impact@davita.com. Together we can give our incident patients the quality and length of life they deserve.

Sincerely,

Dennis Kogod
Chief Operating Officer

Allen R. Nissenson, MD, FACP
Chief Medical Officer

Corporate Office 601 Howard Street, 5th Floor, Oakland, CA 94612 • (415) 764-8722 • davita.com/physicians



FOR IMMEDIATE RELEASE

DaVita's IMPACT Program Reduces Mortality for New Dialysis Patients

Study Shows New Patient Care Model Significantly Improves Patient Outcomes

El Segundo, Calif., (March, 29, 2009) – DaVita Inc., a leading provider of kidney care services for those diagnosed with chronic kidney disease (CKD), today released the findings of a study revealing DaVita's IMPACT™ (Incident Management of Patients, Actions Centered on Treatment) pilot program can significantly reduce mortality rates for new dialysis patients. The study presented at the National Kidney Foundation's Spring Clinical Meeting in Nashville, TN details how the IMPACT patient care model educates and manages dialysis patients within the first 90 days of treatment, when they are most unstable and are at highest risk. In addition to lower mortality rates, patient outcomes improved - confirming the health of this vulnerable patient population is better supported under DaVita's *Relentless Pursuit of Quality*™ care.

The pilot program was implemented with 606 patients completing the IMPACT program over a 12 month period in 44 DaVita centers around the nation. IMPACT focuses on patient education and important clinical outcomes - such as the measurement of adequate dialysis, access placement, anemia, and albumin levels - monitoring the patient's overall health in the first 90 days on dialysis. Data reflects a reduction in annualized mortality rates by eight percent for IMPACT patients compared with non-IMPACT patients in the DaVita network. Given that DaVita has roughly 28,000 new patients starting dialysis every year, this reduction affects a significant number of lives.

In addition, a higher number of IMPACT patients versus non-IMPACT patients had an arteriovenous fistula (AVF) in place. Research shows that fistulas - the surgical connection of an artery to a vein - last longer and are associated with lower rates of infection, hospitalization and death compared to all other access choices.

Allen R. Nissenson, MD, Chief Medical Officer at DaVita says, "The IMPACT program is about quality patient care starting in the first 90 days and extending beyond. Improved outcomes in new dialysis patients translates to better long term results and healthier patients overall."

Researchers applaud the IMPACT program's inclusion of all patients starting dialysis, regardless of their cognitive ability or health status. Enrolling all patients at this early stage in their treatment allows them to better understand their disease and care needs while healthcare providers work to improve their outcomes. Through this program, DaVita mandates reporting on this particular population to better track and manage patients through their incident period.

Dennis Kogod, Chief Operating Officer of DaVita says, "We are thrilled by the promising results IMPACT has had on our new dialysis patients. DaVita continues to be the leader in the kidney care community, and we look forward to rolling out this program to all facilities later this year, to improve the health of all new dialysis patients."

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Poster Presentation
NKF Spring Clinical Meeting
Nashville, TN
March 26-28, 2009

Incident Management of Hemodialysis Patients: Managing the First 90 Days

John Robertson¹, Pooja Goel¹, Grace Chen¹, Ronald Levine¹, Debbie Benner¹, and Amy Burdan¹
¹DaVita Inc., El Segundo, CA, USA

IMPACT (Incident Management of Patients, Actions Centered on Treatment) is a program to reduce mortality and morbidity in new patients during the first 3 months of dialysis, when these patients are most vulnerable. IMPACT was designed to standardize the onboarding process of incident patients from their 0 to 90-day period. We report on an observational (non-randomized), un-blinded study of 606 incident patients evaluated over 12 months (Oct77-Oct08) at 44 US DaVita facilities.

The study focused on 4 key predictive indicators associated with lower mortality and morbidity—anemia, albumin, adequacy and access (4As). IMPACT consisted of:

- (1) Structured New Patient Intake Process with a standardized admission order, referral fax, and an intake checklist;
- (2) 90-day Patient Education Program with an education manual and tracking checklist;
- (3) Tools for 90-day Patient Management Pathway including QOL; and
- (4) Data Monitoring Reports.

Data as of July, 2008 is reported. Patients in the IMPACT group were 60.6 ± 15.1 years old (mean ± SD), 42.8% Caucasian, 61% male with 25% having a fistula. Results showed a reduction in 90-day mortality almost 2 percentage points lower (6.14% vs. 7.98%; $p < 0.10$) among IMPACT versus nonIMPACT patients. Changes among the 4As showed higher albumin levels from 3.5 to 3.6 g/dL (note that some IMPACT patients were on protein supplementation during this period) and patients achieving fistula access during their first 90-days was 25% vs. 21.4%, IMPACT and nonIMPACT, respectively ($p \leq 0.05$). However, only 20.6% of IMPACT patients achieved Hct targets ($33 \leq \text{Hct} \leq 36$) vs. 23.4% for controls ($p < 0.10$); some IMPACT patients may still have >36 -level Hcts. Mean calculated Kt/V was 1.54 for IMPACT patients vs. 1.58 for nonIMPACT patients ($p \leq 0.05$).

IMPACT is a first step toward a comprehensive approach to reduce mortality of incident patients. We believe this focus may help us to better manage CKD as a continuum of care. Long-term mortality measures will help determine if this process really impacts patients in the intended way, resulting in longer lives and better outcomes.

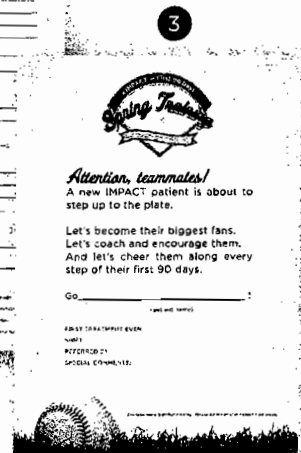
IMPACT Tools

Here's how the IMPACT program will help the team record data, educate patients and monitor their progress in your facilities.

- 1 Standard Order Template, a two-page form with drop-down menus that can be customized into a center-specific template
- 2 Intake Checklist to gather registration and clinical data prior to admission
- 3 Patient Announcement to alert teammates about new incident patients
- 4 Patient Education Book and Flip Chart to teach patients about dialysis
- 5 Tracking Checklist for the team to monitor progress over the first 90 days
- 6 IMPACT Scorecard to track monthly center summary and patient level detail for four clinical indicators: access, albumin, adequacy, anemia

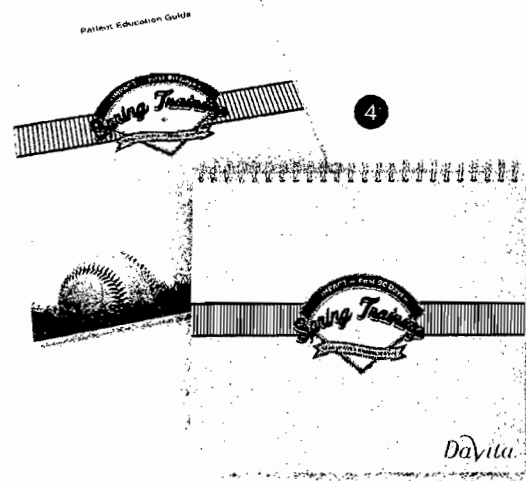
A two-page form with various fields for patient information, including name, date of birth, gender, and medical history. It includes checkboxes for different types of orders and a section for physician orders.

A checklist form for gathering registration and clinical data prior to admission. It includes sections for patient information, medical history, and a checklist of items to be completed.



A scorecard form for tracking monthly center summary and patient level detail for four clinical indicators: access, albumin, adequacy, anemia. It includes a table for patient data and a section for center summary.

A management checklist form for tracking progress over the first 90 days. It includes a table for patient data and a section for center summary.



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DaVita.com

Our Mission

To be the Provider,
Partner and Employer
of Choice

Core Values

Service Excellence
Integrity
Team
Continuous Improvement
Accountability
Fulfillment
Fun



DaVita HealthCare Partners Celebrates Milestones of 2013

Year Marked by Continued Clinical Excellence, Expansion of Patient Services, Company Growth, Global Altruism, Community Leadership

DENVER--(BUSINESS WIRE)--Jan. 8, 2014-- DaVita HealthCare Partners Inc. (NYSE:DVA), one of the nation's largest and most innovative health care communities, released a year-end recap of major milestones and achievements for the company in 2013.

"In 2013, DaVita HealthCare PartnersSM achieved outstanding results on clinical and business metrics and expanded the portfolio of initiatives aimed at improving patient care and the communities we serve," said Kent Thiry, co-chairman and CEO of DaVita HealthCare Partners Inc. "This success is a team effort and speaks to the work of our 50,000 DaVita HealthCare Partners teammates delivering industry-leading clinical outcomes and driving down health care costs that already have saved taxpayers hundreds of millions of dollars."

Major initiatives and highlights for 2013 included:

Clinical Excellence:

- DaVita Survival Rate Leads Kidney Care Industry** – In September, the United States Renal Data System released its 2013 Atlas of Chronic Kidney Disease (CKD) and End Stage Renal Disease (ESRD). The Atlas covers population and treatment data available in 2011; for that year, DaVita had the lowest standard mortality rate in the industry (along with DCI).¹ Through an integrated approach to patient care, DaVita continues to improve survival rates. According to the latest available internal data, gross mortality rate at DaVita fell in 2012 to its lowest level ever at 13.9 percent, a 27 percent decrease since tracking began in 2001. This decrease represents thousands of lives saved over a period of years.
- DaVita Clinical Research[®] (DCR[®]) Launches Biorepository** – In 2013, DCR announced the commercial availability of its biorepository and completes the collection of blood, serum and plasma samples and accompanying annotated clinical data from more than 4,000 patients with end stage renal disease (ESRD). The vision is to be a resource to drive new innovations and advance the knowledge and practice of kidney care. In 2013, DCR cemented agreements with biopharmaceutical and molecular diagnostic companies seeking to leverage the biorepository.
- DaVita's Catheter Rates Fall to Historic Lows** – DaVita continues to see improvement in its efforts to reduce patient central venous catheter (CVC) rates, a major risk factor for serious infection in kidney patients. In 2008, DaVita established CathAway[™], the company's seven-step program for reducing the number of hemodialysis patients dialyzing with CVCs. Since the inception of the program, DaVita has achieved a 45 percent reduction in the number of "Day 90+" catheter patients (i.e., those patients who have been dialyzing at DaVita for 90 days or more with a CVC in place), and the company is now at an all-time low catheter rate of 13 percent for this patient population as of November 2013. DaVita is among the leaders in the industry in the use of fistulas, the "gold standard" for dialysis access.
- DaVita Patient Vaccination Rates Again Top 90 Percent** – Less than a month into flu season, DaVita announced that it had exceeded its goal of vaccinating 90 percent of its dialysis patients for influenza and pneumonia. As of early December 2013, DaVita had vaccinated 91.9 percent of its patients for influenza and 92.7 percent of its patients for pneumonia. Vaccinations are critically important for kidney care patients who are at high risk for complications, helping prevent hospitalizations and even death and supporting quality of life.
- 30,000 DaVita Teammates Participate in Health-Promoting DaVita Vitality Points Program** – The Vitality Points program is designed to reward and encourage participants to be accountable for their own health. About 80 percent of DaVita's health care costs are attributed to preventable risks and lifestyle behaviors. Vitality Points participants become aware of their own health risks and start taking steps to reduce or eliminate them. Historically, the program has been a success: Of the roughly 20,000 teammates who got their Vitality Screenings in consecutive years between 2010 and 2012, 50 percent saw their blood pressure and cholesterol score decline at least a little; 10 percent of those same teammates (2,000 individuals) significantly reduced their health risks related to blood pressure and cholesterol. And while year-over-year results aren't yet available (expected in March 2014), in 2013 more than 30,000 teammates and 8,000 spouses and domestic partners took action by participating in the program.

DaVita is proud of its clinical accomplishments, which have improved and extended the lives of thousands of Medicare beneficiaries. However, in 2014 the kidney community was presented with new challenges due to substantial cuts to Medicare reimbursement. All of these wonderful advancements in care depend on adequate Medicare funding, which is at

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risk like no other time in history.

Patient Service:

- **The New and Improved myDaVita.com Health-Management Platform Launches** – myDaVita.com offers a social networking platform that is now available wherever and whenever a member needs the online kidney community. myDaVita.com members can take control of their kidney care in the palm of their hands with the new myDaVita.com mobile experience. With convenient, on-the-go access to myDaVita.com, it is easier than ever for people to manage their kidney disease. Members have access to a variety of features, including DaVita Diet Helper™ for easy kidney diet meal planning, the DaVita Forums and specialized groups, as well as personalized profiles. DaVita dialysis patients also have access to the DaVita Health Portal™ health-management tool through myDaVita.com.
- **An Enhanced DaVita Diet Helper™ Diet-Management Tool Launches** – First launched in 2007, the highly popular DaVita Diet Helper has undergone changes that are bound to make this coveted kidney diet tool even better. Now users in any stage of kidney disease can get 1,000+ recipes for quick and easy meal planning. The improved experience also includes customizing recipes and meals to their liking, viewing their mobile Nutrition Tracker and Shopping List on the go and checking their nutrition goals with ease.

Business Growth, Thought Leadership:

- **HealthCare Partners® Celebrates Multiple Operational Milestones** – HealthCare Partners (HCP) hit a series of significant milestones in 2013, including the following: being named a top-performing medical group by the Integrated Healthcare Association for the tenth consecutive year; expanding operations into a fifth state with the acquisition of Arizona Integrated Physicians (HCP already provides care for patients in California, Florida, Nevada and New Mexico); adding nearly 60,000 Medicare Advantage patients – an increase of 28 percent; being selected by the Centers for Medicare and Medicaid Services to participate in the Medicare Shared Savings Programs in California, Florida and Nevada; and partnering with leading health plans in Commercial Accountable Care Organizations.
- **Studies Show DaVita Rx® Patients Live Longer, Have Fewer Hospital Visits** – A 2013 independent study showed that patients who use DaVita Rx, the world's first and largest full-service pharmacy dedicated to serving the unique needs of kidney patients, have a 21 percent lower risk of death and experience 14 percent fewer hospital visits per year than patients who do not use DaVita Rx.
- **DaVita's International Expansion Continues** – As of December 2013, DaVita had 67 clinics located in 10 countries outside the U.S. In 2013, DaVita entered four new countries: Poland, Portugal, Taiwan and Colombia.
- **VillageHealth® Garners Top Award** – SCAN Health Plan's Chronic Condition Special Needs Plan (C-SNP) for individuals with end stage renal disease – called VillageHealth (a joint partnership with DaVita) – received the highest patient satisfaction rating of any C-SNP in California. VillageHealth received a 92 percent satisfaction rating in Medicare's Consumer Assessment of Healthcare Providers and Systems (CAHPS) 2013 survey.

Corporate Citizenship, Education, Empowerment:

- **DaVita Provides Nearly 13,000 Pairs of Shoes to Underserved Children** – Through a nationwide initiative known as "Shoes-a-palooza," DaVita teammates committed to donating 5,000 pairs of shoes through a partnership with Shoes That Fit, a Claremont, Calif.-based charity whose mission is to provide new shoes to children in need so they can attend school in comfort and with dignity, and be better prepared to learn and play. DaVita teammates far exceeded that goal and provided 12,915 pairs of new shoes to children in 167 schools nationwide.
- **Bridge of Life Brings Dialysis to Previously Unserved Areas** – In 2013, nearly 50 volunteers from Bridge of Life – DaVita Medical Missions™, an independent 501(c)(3) nonprofit organization, worked together to complete 15 missions in 11 countries, during which volunteers and partners helped to install or repair 77 dialysis machines and train more than 50 kidney care professionals, bringing treatment and quality care to an additional 420 people around the world.
- **Tour DaVita® – DaVita's annual charity bike ride, Tour DaVita**, raised \$1 million to support The Kidney TRUST in 2013. The Kidney TRUST, an independent 501(c)(3) nonprofit organization, offers no-cost kidney disease screenings in nonmedical settings. The proceeds from Tour DaVita will help fund future screenings by The Kidney TRUST as well as its mission to educate communities around the country on kidney health, including kidney disease risk factors.
- **DaVita Provides Leadership, Management Training to Nearly 10,000 Teammates** – Reflecting a steadfast commitment to delivering advanced educational opportunities to DaVita teammates, in 2013 more than 9,700 teammates benefited from the various award-winning curricula of DaVita University. Additionally, nearly 5,000 teammates from every level of the company attended DaVita Academies, which are two-day introductions to DaVita culture and to important leadership practices to use with their teams and in their communities.
- **DaVita Executives Spend the Day Supporting Clinical Operations in Dialysis Centers** – More than 200 DaVita executives (vice president and higher), including company co-Chairman and CEO Kent Thiry, served in clinics from Washington to Florida and New York to California. While they are not providing direct patient care, they supported the

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clinical care team by performing a range of other duties, such as cleaning, organizing, stocking supplies and visiting with patients.

- **DaVita Educational Programs, Cultural Displays Win Major Awards** – In 2013 DaVita's "Wisdom" department won numerous awards for its representation of the DaVita culture through various vehicles:
 - International Gold Quill, Silver Quill and Ragan Health & PR Awards for *Stories of the DaVita Village* magazine
 - Video Award of Distinction by Videographer Awards
 - Platinum Hermes Creative Award for collateral at DaVita's 2012 "Nationwide" event
 - Gold Hermes Award for a recruiting email campaign
 - Platinum MarCom Award for promoting DaVita brand and culture in a new office in Federal Way, Wash.
 - MarCom Gold Award for an educational piece on home dialysis
 - MarCom Awards for branding and marketing initiatives in Poland
- **DaVita Way of Giving** – For the third year in a row, DaVita teammates chose charities in their communities to support financially as part of "DaVita Way of Giving," the company's locally focused charitable giving initiative. This year, teammates donated \$1.2 million to help nonprofit organizations throughout the United States grow and thrive.

Awards

In 2013, DaVita won nearly 70 major awards, including the following:

Business Excellence

- **World's Most Admired Companies** – DaVita was named the most innovative company on *FORTUNE®* Magazine's World's Most Admired Companies' 2013 ranking of health care facilities. This marked the fourth consecutive year DaVita has been ranked no. 1 in innovation and the eighth consecutive year DaVita has been recognized on the World's Most Admired Companies industry list.
- **50 Top Performing Companies** – DaVita was named a top performer by Bloomberg *BusinessWeek*.
- **100 Most Influential People in Health Care** – Kent Thiry was ranked *number 11* among the most influential people in U.S. health care by *Modern Healthcare*. We believe this should be called the "most influential companies" list because this recognition is both a testament to our teammates' hard work and commitment to patients and an indication of growing acknowledgement of the contributions DaVita HealthCare Partners makes to the health care industry and to the world at large.

Caring for Our Patients

- **Renal Physicians Association's Patient Safety Improvement Award** – DaVita stands atop the "Adherence to Procedures" category.
- **Case in Point Platinum Award** – Patient Pathways garnered the top honor in the "Best Discharge Planning" category.
- **National Health Information Awards** – DaVita took home three awards plus a Best in Show award: Gold and Best in Show for The Compass, a patient education magazine; silver for Kidney Diet Delights, a kidney-friendly cookbook; and silver for Kidney Smart magazine, vol. 2, an in-depth educational tool for patients transitioning to dialysis.

Caring for Each Other

- **Best Places to Work** – DaVita was voted among the top places to work in Denver, Nashville, Philadelphia and the San Francisco Bay Area.
- **2013 Training Top 125** – For the ninth consecutive year, *Training Magazine* named DaVita a leading organization that excels at employee development.
- **Most Democratic Workplaces** – For the sixth straight year DaVita was ranked among the world's most democratically operated workplaces by WorldBlu – still the only health care company and the only Fortune 500® company so recognized.

Caring for Our World

- **Communitas Community Service Award** – DaVita was recognized in the company-sponsored volunteer project category for Shoes-a-palooza.

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- **EPA Green Power Partnership** – DaVita was included in the Environmental Protection Agency Green Power Partnership lists of Fortune 500 companies that lead in supporting renewable generation capacity since 2009.

Military Awards

- **Freedom Award** – DaVita was honored with the highest military-friendly employer award presented by the U.S. government. DaVita became the first kidney care provider to win this award.
- **Best for Vets** – DaVita was recognized by *Military Times Edge* as a "Best for Vets" employer. DaVita was also included on the list for best employers for reservists.
- **Military Spouse** – DaVita was recognized as a top employer for military spouses by *Military Spouse Magazine*.
- **Patriot Award** – For the second year in a row, DaVita was recognized with the Department of Defense's prestigious Patriot Award for its support of military personnel (including reservists).

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About DaVita

DaVita is the dialysis division of DaVita HealthCare Partners Inc., a Fortune 500® company that, through its operating divisions, provides a variety of health care services to patient populations throughout the United States and abroad. A leading provider of kidney care in the United States, DaVita delivers dialysis services to patients with chronic kidney failure and end stage renal disease. DaVita strives to improve patients' quality of life by innovating clinical care, and by offering integrated treatment plans, personalized care teams and convenient health-management services. As of Sept. 30, 2013, DaVita operated or provided administrative services at 2,042 outpatient dialysis centers located in the United States serving approximately 166,000 patients. The company also operated 66 outpatient dialysis centers located in 10 countries outside the United States. DaVita supports numerous programs dedicated to creating positive, sustainable change in communities around the world. The company's leadership development initiatives and social responsibility efforts have been recognized by Fortune, Modern Healthcare, Newsweek and WorldBlu. For more information, please visit DaVita.com.

¹ USRDS 2013 Atlas of ESRD

Source: DaVita HealthCare Partners Inc.

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DaVita's Approach to Integrated Care Nationally Recognized

Patient Pathways, VillageHealth Recognized with National Awards

DaVita Kidney Care, a division of DaVita HealthCare Partners Inc. (NYSE: DVA) and a leading provider of kidney care services, today announced that its approach to integrated care has been recognized with two Dorland Health "Case In Point" Platinum Awards, a unique awards program that recognizes the most successful and innovative case-management programs working to improve health care across the care continuum.



DaVita's approach to integrated kidney care management includes partnering with patients, physicians, health systems, Accountable Care Organizations (ACOs) and payers to provide holistic integrated care for individuals with chronic kidney disease (CKD) and end stage renal disease (ESRD).

"We've been investing and growing our integrated kidney care capabilities for more than a decade and are honored to be recognized for our innovations to improve clinical outcomes while addressing the unique, complex needs of kidney care patients," said Javier Rodriguez, CEO of DaVita Kidney Care.

The two programs that won awards for integrated care are Patient Pathways and VillageHealth, both subsidiaries of DaVita.

Pathways Care Management, Patient Pathways – Winner: Best Case Management in Acute Settings, Provider Program

Pathways Care Management (PCM) by Patient Pathways supplements partnering hospitals' staffs with onsite renal nurses, patient liaisons and telephonic renal nurses who are experts in complex kidney patient care management, discharge planning, and post discharge care coordination and coaching.

Founded in 2007, Patient Pathways has improved the quality of life for more than 200,000 dialysis patients in more than 350 hospitals nationwide. The program's goals include improving the transition from the inpatient to the outpatient setting; assisting hospital partners with clinically appropriate reductions in hospital readmissions, avoidable admissions and length of stay; reducing avoidable acute dialysis treatments; and enhancing the patient experience and quality of life.

Since PCM's pilot launch in 2010 and subsequent program launch in 2013, the program has impacted over 5,000 patients and reduced hospital readmission rates an average of 27 percent, saving our hospital partners more than \$11 million. Compared to Patient Pathways' original discharge planning service, PCM has proven 50 percent more effective in reducing all-cause readmission rates for ESRD patients.

VillageHealth Integrated Care Management – Winner: Best Disease Management/Population Health

VillageHealth's Integrated Care Management (ICM) services for payers and ACOs provides CKD and ESRD population health management delivered by a team of dedicated and highly skilled nurses who support patients both in the field and over the phone. These nurses use VillageHealth's industry-leading renal decision support and risk stratification software to manage a patient's coordinated needs.

Since 1996, VillageHealth has innovated to become the country's largest renal National Committee for Quality Assurance (NCQA)-accredited disease management program. ICM partners with patients, providers and care team members, focusing on the root causes of unnecessary hospitalizations such as unplanned dialysis starts, infection, fluid overload and medication management.

Improved clinical outcomes and reduced hospital readmission rates have contributed to improved quality of life for patients. VillageHealth ICM has delivered up to a 15 percent reduction in non-dialysis medical costs for ESRD patients. Applied to our managed ESRD population, this represents an annual savings of more than \$30 million.

Winners of the "Case In Point" Platinum Awards were announced May 5, 2014, at the Gaylord National Resort and Convention Center in National Harbor, Maryland.

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About DaVita Kidney Care

DaVita Kidney Care is a division of DaVita HealthCare Partners Inc., a Fortune 500® company that, through its operating divisions, provides a variety of health care services to patient populations throughout the United States and abroad. A leading provider of dialysis services in the United States, DaVita Kidney Care treats patients with chronic kidney failure and end stage renal disease. DaVita Kidney Care strives to improve patients' quality of life by innovating clinical care, and by offering integrated treatment plans, personalized care teams and convenient health-management services. As of March 31, 2014, DaVita Kidney Care operated or provided administrative services at 2,098 outpatient dialysis centers located in the United States serving approximately 165,000 patients. The company also operated 75 outpatient dialysis centers located in 10 countries outside the United States. DaVita Kidney Care supports numerous programs dedicated to creating positive, sustainable change in communities around the world. The company's leadership development initiatives and social responsibility efforts have been recognized by Fortune, Modern Healthcare, Newsweek and WorldBlu. For more information, please visit DaVita.com.

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SOURCE DaVita



DaVita's Teammate-Focused Culture Gains National and Local Awards

DaVita receives LearningElite, WorldBlu and Top Workplaces honors

DENVER, April 16, 2014 /PRNewswire-USNewswire/ -- DaVita, a division of DaVita HealthCare Partners Inc. (NYSE: DVA) and a leading provider of kidney care services, today announced it received three major national and local awards for its focus on its teammates: WorldBlu Most Democratic Workplaces, Top Workplaces Colorado and LearningElite Silver.



"At DaVita, we care for our teammates with the same passion and intensity that goes into the care of our patients and communities in which we operate," said Javier Rodriguez, CEO of DaVita Kidney Care. "Inspired teammates who continue to grow personally and professionally are engaged and take better care of our patients."

- DaVita appeared on WorldBlu's list of most democratic workplaces for the seventh consecutive year. To compile the list, WorldBlu conducts a survey of organizations' teammates to determine the level of democracy practiced.
- WorkplaceDynamics recognized DaVita as one of the top workplaces in Colorado for the third year in a row. WorkplaceDynamics bases its selections on employee input.
- Finally, DaVita was also named a Silver LearningElite organization for 2014 by *Chief Learning Officer* magazine. Lauded for creating and implementing exemplary teammate development practices that deliver measurable business value, DaVita HealthCare Partners ranked No. 29 in a record-breaking field of more than 200 companies that applied.

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About DaVita HealthCare Partners

DaVita HealthCare Partners, a Fortune 500® company, is the parent company of DaVita Kidney Care and HealthCare Partners. DaVita Kidney Care is a leading provider of kidney care in the United States and abroad, delivering dialysis services to patients with chronic kidney failure and end stage renal disease. As of Dec. 31, 2013, DaVita Kidney Care operated or provided administrative services at 2,074 outpatient dialysis centers in the United States serving approximately 168,000 patients, and at 73 centers in 10 countries outside of the United States. HealthCare Partners® manages and operates medical groups and affiliated physician networks in California, Nevada, Florida, Arizona and New Mexico in its pursuit to deliver excellent-quality health care in a dignified and compassionate manner. As of Dec. 31, 2013, HealthCare Partners provided integrated care management for approximately 765,000 managed care patients. For more information, please visit DaVitaHealthCarePartners.com.

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SOURCE DaVita HealthCare Partners

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FORTUNE Magazine Names DaVita Among Most Admired Companies for Ninth Consecutive Year

DENVER, March 5, 2014 /PRNewswire-USNewswire/ -- DaVita, a division of DaVita HealthCare Partners Inc. (NYSE: DVA) and a leading provider of kidney care services, has been recognized as one of FORTUNE® Magazine's Most Admired Companies in 2014. This marks the fifth consecutive year DaVita has been ranked no. 1 in innovation for health care facilities and the ninth consecutive year DaVita has earned the honor as one of the World's Most Admired Companies by FORTUNE.



DaVita ranked first overall among health care facilities and was the second highest-rated company in Colorado.

"Being recognized by FORTUNE for the ninth consecutive year is a huge honor," said Kent Thiry, co-chairman and CEO of DaVita HealthCare Partners. "This affirms our belief that putting the quality of life of our patients and teammates first makes a difference as we strive to be a top innovator in health care."

FORTUNE surveys company executives, board members and industry analysts to compile its rankings. Within the health care facility industry, DaVita was top-ranked in innovation, social responsibility and quality of products and services. The other categories used to determine scores were people management, use of corporate assets, quality of management, financial soundness, long-term investment and global competitiveness.

The FORTUNE World's Most Admired Companies list includes organizations such as Amazon, Apple and Johnson & Johnson. To see the full list of 2014 FORTUNE World's Most Admired Companies, visit http://money.cnn.com/magazines/fortune/most-admired/2014/list/?iid=wma14_sp_full.

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SOURCE DaVita Inc.

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DaVita Gives \$1.2 Million to Nonprofits Across the US

DaVita Way of Giving Gives Teammates Opportunity to Make a Difference

DENVER--(BUSINESS WIRE)--Feb. 10, 2014-- DaVita, the kidney care division of DaVita HealthCare Partners Inc. (NYSE: DVA) and a leading provider of kidney care services, announced that its teammates donated \$1.2 million to charities in more than 1,100 communities across the United States as part of the "DaVita Way of Giving."

For the third year in a row, DaVita teammates in centers across the U.S. democratically chose local charities to support as part of the DaVita® Way of Giving, the company's locally focused charitable giving initiative that helps 501(c)(3) non-profit organizations grow and thrive. Charities included relief organizations, animal shelters, food banks, children's organizations, crisis centers, health clinics and many more.

"At DaVita, we believe taking care of one another – both at our dialysis centers and in the greater community – is vital to our growth and well-being as a company," said Steve Priest, DaVita's chief wisdom officer. "As a community first, and a company second, we strive to make a difference in the welfare of the communities where we live and work."

As a part of the DaVita Way of Giving, DaVita centers across the nation also contributed \$25,000 to Typhoon Haiyan relief efforts through the American Red Cross. The Red Cross continues to distribute much-needed supplies and support, while continually assessing the needs of those most affected.

In addition to monetary donations, many teammates also volunteered their time to help these charities through community service projects – known internally as Village Service Days. Projects included holiday parties for children and food drives, among others.

DaVita is committed to improving the quality of life for those diagnosed with chronic kidney disease and is dedicated to spreading ripples of citizen leadership through its Trilogy of Care – Caring for Our Patients, Caring for Each Other and Caring for Our World.

For more information about DaVita's community engagement efforts, please visit DaVita.com/CommunityCare.

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About DaVita

DaVita is the dialysis division of DaVita HealthCare Partners Inc., a Fortune 500® company that, through its operating divisions, provides a variety of health care services to patient populations throughout the United States and abroad. A leading provider of kidney care in the United States, DaVita delivers dialysis services to patients with chronic kidney failure and end stage renal disease. DaVita strives to improve patients' quality of life by innovating clinical care, and by offering integrated treatment plans, personalized care teams and convenient health-management services. As of Sept. 30, 2013, DaVita operated or provided administrative services at 2,042 outpatient dialysis centers located in the United States serving approximately 166,000 patients. The company also operated 66 outpatient dialysis centers located in 10 countries outside the United States. DaVita supports numerous programs dedicated to creating positive, sustainable change in communities around the world. The company's leadership development initiatives and social responsibility efforts have been recognized by Fortune, Modern Healthcare, Newsweek and WorldBlu. For more information, please visit DaVita.com.

Source: DaVita

Media:
DaVita
David Gilles, 303-876-7497
David.Gilles@DaVita.com



DaVita Delivers First-of-its-Kind Dialysis Treatment in the U.S.

Hemodiafiltration Trial Launches in Colorado Springs

DaVita Kidney Care, a division of DaVita HealthCare Partners Inc. (NYSE: DVA) and a leading provider of kidney care services, today announced it is now delivering hemodiafiltration treatments to select patients in Colorado Springs as part of a six-month trial program. This marks the first delivery of hemodiafiltration in the United States.



Hemodiafiltration differs from hemodialysis – the country's most common dialysis method – in that hemodiafiltration incorporates the standard hemodialysis process but adds an extra step designed to remove even larger toxin particles, thereby further cleansing a patient's blood. Hemodiafiltration is commonly practiced in Europe but until recently there was no FDA approved device for use in the U.S.

"At DaVita, we are always evaluating ways to improve patient outcomes and experience during dialysis treatments," said Shaun Collard, vice president of clinical operations at DaVita. "We are excited to have the opportunity to be the first U.S. provider to evaluate this treatment."

The evaluation will be performed at DaVita's North Colorado Springs Clinic over a period of six months. During this period DaVita clinical experts will determine whether there are improved outcomes of dialysis treatment and patient quality of life compared to those associated with hemodialysis.

"DaVita has a culture of clinical innovation which has driven second-to-none patient outcomes throughout the country," said Dr. Robert Provenzano, M.D., FACP, vice president in DaVita's Office of the Chief Medical Officer. "We are constantly evaluating the efficacy of kidney care treatments and hemodiafiltration has shown potential benefits internationally."

This evaluation supports DaVita's commitment to clinical leadership. DaVita has improved clinical outcomes for the past 14 consecutive years, benefits of which include fewer hospitalizations, significant savings to taxpayers and a better quality of life for patients.

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About DaVita Kidney Care

DaVita Kidney Care is a division of DaVita HealthCare Partners Inc., a Fortune 500® company that, through its operating divisions, provides a variety of health care services to patient populations throughout the United States and abroad. A leading provider of dialysis services in the United States, DaVita Kidney Care treats patients with chronic kidney failure and end stage renal disease. DaVita Kidney Care strives to improve patients' quality of life by innovating clinical care, and by offering integrated treatment plans, personalized care teams and convenient health-management services. As of March 31, 2014, DaVita Kidney Care operated or provided administrative services at 2,098 outpatient dialysis centers located in the United States serving approximately 165,000 patients. The company also operated 75 outpatient dialysis centers located in 10 countries outside the United States. DaVita Kidney Care supports numerous programs dedicated to creating positive, sustainable change in communities around the world. The company's leadership development initiatives and social

responsibility efforts have been recognized by Fortune, Modern Healthcare, Newsweek and WorldBlu. For more information, please visit DaVita.com.

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Logo - <http://photos.prnewswire.com/prnh/20140303/LA75036LOGO-b>

SOURCE DaVita

Attachment - 11A

DaVita HealthCare Partners, Inc.							
Illinois Facilities							
Regulatory Name	Address 1	Address 2	City	County	State	Zip	Medicare Certification Number
Adams County Dialysis	436 N 10TH ST		QUINCY	ADAMS	IL	62301-4152	14-2711
Alton Dialysis	3511 COLLEGE AVE		ALTON	MADISON	IL	62002-5009	14-2619
Arlington Heights Renal Center	17 WEST GOLF ROAD		ARLINGTON HEIGHTS	COOK	IL	60005-3905	14-2628
Barrington Creek	28160 W. NORTHWEST HIGHWAY		LAKE BARRINGTON	LAKE	IL	60010	14-2736
Belvidere Dialysis	1755 BELOIT ROAD		BELVIDERE	BOONE	IL	61008	
Benton Dialysis	1151 ROUTE 14 W		BENTON	FRANKLIN	IL	62812-1500	14-2608
Beverly Dialysis	8109 SOUTH WESTERN AVE		CHICAGO	COOK	IL	60620-5939	14-2638
Big Oaks Dialysis	5623 W TOUHY AVE		NILES	COOK	IL	60714-4019	14-2712
Buffalo Grove Renal Center	1291 W. DUNDEE ROAD		BUFFALO GROVE	COOK	IL	60089-4009	14-2650
Centralia Dialysis	1231 STATE ROUTE 161		CENTRALIA	MARION	IL	62801-6739	14-2609
Chicago Heights Dialysis	177 W JOE ORR RD	STE B	CHICAGO HEIGHTS	COOK	IL	60411-1733	14-2635
Churchview Dialysis	5970 CHURCHVIEW DR		ROCKFORD	WINNEBAGO	IL	61107-2574	14-2640
Cobblestone Dialysis	934 CENTER ST	STE A	ELGIN	KANE	IL	60120-2125	14-2715
Crystal Springs Dialysis	720 COG CIRCLE		CRYSTAL LAKE	MCHENRY	IL	60014-7301	14-2716
Decatur East Wood Dialysis	794 E WOOD ST		DECATUR	MACON	IL	62523-1155	14-2599
Dixon Kidney Center	1131 N GALENA AVE		DIXON	LEE	IL	61021-1015	14-2651
Driftwood Dialysis	1808 SOUTH WEST AVE		FREEDPORT	STEPHENSON	IL	61032-6712	14-2747
Edwardsville Dialysis	235 S BUCHANAN ST		EDWARDSVILLE	MADISON	IL	62025-2108	14-2701
Effingham Dialysis	904 MEDICAL PARK DR	STE 1	EFFINGHAM	EFFINGHAM	IL	62401-2193	14-2580
Emerald Dialysis	710 W 43RD ST		CHICAGO	COOK	IL	60609-3435	14-2529
Evanston Renal Center	1715 CENTRAL STREET		EVANSTON	COOK	IL	60201-1507	14-2511
Grand Crossing Dialysis	7319 S COTTAGE GROVE AVENUE		CHICAGO	COOK	IL	60619-1909	14-2728
Freeport Dialysis	1028 S KUNKLE BLVD		FREEDPORT	STEPHENSON	IL	61032-6914	14-2642
Garfield Kidney Center	3250 WEST FRANKLIN BLVD		CHICAGO	COOK	IL	60624-1509	
Granite City Dialysis Center	9 AMERICAN VLG		GRANITE CITY	MADISON	IL	62040-3706	14-2537
Hazel Crest Renal Center	3470 WEST 183rd STREET		HAZEL CREST	COOK	IL	60429-2428	14-2622
Illini Renal Dialysis	507 E UNIVERSITY AVE		CHAMPAIGN	CHAMPAIGN	IL	61820-3828	14-2633
Jacksonville Dialysis	1515 W WALNUT ST		JACKSONVILLE	MORGAN	IL	62650-1150	14-2581
Jerseyville Dialysis	917 S STATE ST		JERSEYVILLE	JERSEY	IL	62052-2344	14-2636
Kankakee County Dialysis	581 WILLIAM R LATHAM SR DR	STE 104	BOURBONNAIS	KANKAKEE	IL	60914-2439	14-2685
Kenwood Dialysis	4259 S COTTAGE GROVE AVENUE		CHICAGO	COOK	IL	60653	14-2717

DaVita HealthCare Partners, Inc.								
Illinois Facilities								
Regulatory Name	Address 1	Address 2	City	County	State	Zip	Medicare Certification Number	
Lake County Dialysis Services	565 LAKEVIEW PARKWAY	STE 176	VERNON HILLS	LAKE	IL	60061	14-2552	
Lake Villa Dialysis	37809 N IL ROUTE 59		LAKE VILLA	LAKE	IL	60046-7332	14-2666	
Lawndale Dialysis	3934 WEST 24TH ST		CHICAGO	COOK	IL	60623		
Lincoln Dialysis	2100 WEST FIFTH		LINCOLN	LOGAN	IL	62656-9115	14-2582	
Lincoln Park Dialysis	3157 N LINCOLN AVE		CHICAGO	COOK	IL	60657-3111	14-2528	
Litchfield Dialysis	915 ST FRANCES WAY		LITCHFIELD	MONTGOMERY	IL	62056-1775	14-2583	
Little Village Dialysis	2335 W CERMAK RD		CHICAGO	COOK	IL	60608-3811	14-2668	
Logan Square Dialysis	2838 NORTH KIMBALL AVE		CHICAGO	COOK	IL	60618	14-2534	
Loop Renal Center	1101 SOUTH CANAL STREET		CHICAGO	COOK	IL	60607-4901	14-2505	
Macon County Dialysis	1090 W MCKINLEY AVE		DECATUR	MACON	IL	62526-3208	14-2584	
Marion Dialysis	324 S 4TH ST		MARION	WILLIAMSON	IL	62959-1241	14-2570	
Markham Renal Center	3053-3055 WEST 159TH STREET		MARKHAM	COOK	IL	60428-4026	14-2575	
Maryville Dialysis	2130 VADALABENE DR		MARYVILLE	MADISON	IL	62062-5632	14-2634	
Mattoon Dialysis	6051 DEVELOPMENT DRIVE		CHARLESTON	COLES	IL	61938-4652	14-2585	
Metro East Dialysis	5105 W MAIN ST		BELLEVILLE	SAINT CLAIR	IL	62226-4728	14-2527	
Montclare Dialysis Center	7009 W BELMONT AVE		CHICAGO	COOK	IL	60634-4533	14-2649	
Mount Vernon Dialysis	1800 JEFFERSON AVE		MOUNT VERNON	JEFFERSON	IL	62864-4300	14-2541	
Mt. Greenwood Dialysis	3401 W 111TH ST		CHICAGO	COOK	IL	60655-3329	14-2660	
Olney Dialysis Center	117 N BOONE ST		OLNEY	RICHLAND	IL	62450-2109	14-2674	
Olympia Fields Dialysis Center	4557B LINCOLN HWY	STE B	MATTESON	COOK	IL	60443-2318	14-2548	
Palos Park Dialysis	13155 S LaGRANGE ROAD		ORLAND PARK	COOK	IL	60462-1162	14-2732	
Pittsfield Dialysis	640 W WASHINGTON ST		PITTSFIELD	PIKE	IL	62363-1350	14-2708	
QRC - Carpentersville	2203 RANDALL ROAD		CARPENTERSVILLE	KANE	IL	60110		
QRC - Marengo	910 GREENLEE STREET	STE B	MARENGO	MCHENRY	IL	60152		
Red Bud Dialysis	LOT 4 IN 1ST ADDITION OF EAST INDUSTRIAL PARK		RED BUD	RANDOLPH	IL	62278		
Robinson Dialysis	1215 N ALLEN ST	STE B	ROBINSON	CRAWFORD	IL	62454-1100	14-2714	
Rockford Dialysis	3339 N ROCKTON AVE		ROCKFORD	WINNEBAGO	IL	61103-2839	14-2647	
Roxbury Dialysis Center	622 ROXBURY RD		ROCKFORD	WINNEBAGO	IL	61107-5089	14-2665	

DaVita HealthCare Partners, Inc.							
Illinois Facilities							
Regulatory Name	Address 1	Address 2	City	County	State	Zip	Medicare Certification Number
Rushville Dialysis	112 SULLIVAN DRIVE		RUSHVILLE	SCHUYLER	IL	62681-1293	14-2620
Sauget Dialysis	2061 GOOSE LAKE RD		SAUGET	SAINT CLAIR	IL	62206-2822	14-2561
Schaumburg Renal Center	1156 S ROSELLE ROAD		SCHAUMBURG	COOK	IL	60193-4072	14-2654
Shiloh Dialysis	1095 NORTH GREEN MOUNT RD		SHILOH	ST CLAIR	IL	62269	14-2753
Silver Cross Renal Center - Morris	1551 CREEK DRIVE		MORRIS	GRUNDY	IL	60450	14-2740
Silver Cross Renal Center - New Lenox	1890 SILVER CROSS BOULEVARD		NEW LENOX	WILL	IL	60451	14-2741
Silver Cross Renal Center - West	1051 ESSINGTON ROAD		JOLIET	WILL	IL	60435	14-2742
South Holland Renal Center	16136 SOUTH PARK AVENUE		SOUTH HOLLAND	COOK	IL	60473-1511	14-2544
Springfield Central Dialysis	932 N RUTLEDGE ST		SPRINGFIELD	SANGAMON	IL	62702-3721	14-2586
Springfield Montvale Dialysis	2930 MONTVALE DR	STE A	SPRINGFIELD	SANGAMON	IL	62704-5376	14-2590
Springfield South	2930 SOUTH 6th STREET		SPRINGFIELD	SANGAMON	IL	62703	14-2733
Stonecrest Dialysis	1302 E STATE ST		ROCKFORD	WINNEBAGO	IL	61104-2228	14-2615
Stony Creek Dialysis	9115 S CICERO AVE		OAK LAWN	COOK	IL	60453-1895	14-2661
Stony Island Dialysis	8725 S STONY ISLAND AVE		CHICAGO	COOK	IL	60617-2709	14-2718
Sycamore Dialysis	2200 GATEWAY DR		SYCAMORE	DEKALB	IL	60178-3113	14-2639
Taylorville Dialysis	901 W SPRESSER ST		TAYLORVILLE	CHRISTIAN	IL	62568-1831	14-2587
Tazewell County Dialysis	1021 COURT STREET		PEKIN	TAZEWELL	IL	61554	
Timber Creek Dialysis	1001 S. ANNIE GLIDDEN ROAD		DEKALB	DEKALB	IL	60115	
TRC Children's Dialysis Center	2611 N HALSTED ST		CHICAGO	COOK	IL	60614-2301	14-2604
Vandalia Dialysis	301 MATTES AVE		VANDALIA	FAYETTE	IL	62471-2061	14-2693
Waukegan Renal Center	1616 NORTH GRAND AVENUE	STE C	Waukegan	COOK	IL	60085-3676	14-2577
Wayne County Dialysis	303 NW 11TH ST	STE 1	FAIRFIELD	WAYNE	IL	62837-1203	14-2688
West Lawn Dialysis	7000 S PULASKI RD		CHICAGO	COOK	IL	60629-5842	14-2719
West Side Dialysis	1600 W 13TH STREET		CHICAGO	COOK	IL	60608	
Whiteside Dialysis	2600 N LOCUST	STE D	STERLING	WHITESIDE	IL	61081-4602	14-2648
Woodlawn Dialysis	5060 S STATE ST		CHICAGO	COOK	IL	60609	14-2310

Kathryn Olson
Chair
Illinois Health Facilities and Services Review Board
525 West Jefferson Street, 2nd Floor
Springfield, Illinois 62761

Dear Chair Olson:

I hereby certify under penalty of perjury as provided in § 1-109 of the Illinois Code of Civil Procedure, 735 ILCS 5/1-109 that no adverse action as defined in 77 IAC 1130.140 has been taken against any in-center dialysis facility owned or operated by DaVita HealthCare Partners Inc. or Cagles Dialysis, LLC in the State of Illinois during the three year period prior to filing this application.

Additionally, pursuant to 77 Ill. Admin. Code § 1110.230(a)(3)(C), I hereby authorize the Health Facilities and Services Review Board ("HFSRB") and the Illinois Department of Public Health ("IDPH") access to any documents necessary to verify information submitted as part of this application for permit. I further authorize HFSRB and IDPH to obtain any additional information or documents from other government agencies which HFSRB or IDPH deem pertinent to process this application for permit.

Sincerely,



Print Name: Arturo Sida
Its: Assistant Corporate Secretary
DaVita HealthCare Partners Inc.

Subscribed and sworn to me

This ____ day of _____, 2014

See Attached

Notary Public

State of California

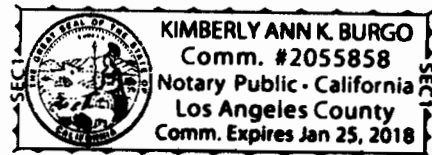
County of Los AngelesOn April 3, 2014 before me, Kimberly Ann K. Burgo, Notary Public
(here insert name and title of the officer)personally appeared Arturo Sida

who proved to me on the basis of satisfactory evidence to be the person(s) whose name(s) is/are subscribed to the within instrument and acknowledged to me that he/she/they executed the same in his/her/their authorized capacity(ies), and that by his/her/their signature(s) on the instrument the person(s), or the entity upon behalf of which the person(s) acted, executed the instrument.

I certify under PENALTY OF PERJURY under the laws of the State of California that the foregoing paragraph is true and correct.

WITNESS my hand and official seal.

Signature

Kimberly Ann K. Burgo

(Seal)

OPTIONAL INFORMATION

Law does not require the information below. This information could be of great value to any person(s) relying on this document and could prevent fraudulent and/or the reattachment of this document to an unauthorized document(s)

DESCRIPTION OF ATTACHED DOCUMENTTitle or Type of Document: Secretary's Certificate - Ltr to K. OlsonDocument Date: April 3, 2014 Number of Pages: one (1)Signer(s) if Different Than Above: No

Other Information: _____

CAPACITY(IES) CLAIMED BY SIGNER(S)Signer's Name(s): Arturo Sida☐ Individual☒ Corporate Officer

(Title(s))

☐ Partner☐ Attorney-in-Fact☐ Trustee☐ Guardian/Conservator☒ Other: Assistant Corporate Secretary**SIGNER IS REPRESENTING:**Name of Person(s) or Entity(ies): Cagles Dialysis, LLC

Section III, Background, Purpose of the Project, and Alternatives – Information Requirements
Criterion 1110.230(b) – Background, Purpose of the Project, and Alternatives

Purpose of Project

1. The purpose of the project is to improve access to life sustaining dialysis services to the residents of the Chicago Ridge community where there is a need for 86 additional dialysis stations. Based upon the ESRD Utilization Data reported to the IDPH for the quarter ending March 31, 2014, the average utilization for facilities within 20 minutes of the proposed facility was 76%, which is just under the State standard.

This is not surprising given the immense size of the facility's proposed medical director's practice. Dr. Sreya Pallath's practice, J.R. Nephrology & Associates, P.C. is treating 1,084 Stage 3, 4 and 5 CKD patients, an increase of 293 patients, or 37.0%, since previously filing this application. Nearly all of these patients reside within 30 minutes normal travel time of the proposed facility. In fact, 179 Stage 4 and 5 CKD patients reside within 20 minutes of the proposed facility, an increase of 42 Stage 4 and 5 patients (or 30.7%), from our earlier application. See Appendix 1. Conservatively, based upon attrition due patient death, transplant, return of function, or relocation, Dr. Pallath anticipates that approximately 113 of these patients will initiate dialysis at the proposed facility within 12 to 24 months following project completion. (113 is an increase of 26 patients, or 29.9%, from the previous application.)

This facility is necessary to provide sufficient access to care for these CKD patients. Dr. Pallath's practice is currently treating ESRD patients at Stony Creek Dialysis, West Lawn Dialysis, and Beverly Dialysis, which are collectively operating at 89.5% utilization. As a result, without operating a fourth shift, these facilities cannot accommodate Dr. Pallath's already large, and growing, patient-base. This, coupled with high utilization in the service area, supports the need for a new 16-station facility.

The establishment of a 16-station dialysis facility will improve access to necessary dialysis treatment for those individuals in the Chicago Ridge community who suffer from ESRD. ESRD patients are typically chronically ill individuals and adequate access to dialysis services is essential to their well-being.

2. A map of the market area for the proposed facility is attached at Attachment – 12A. The market area encompasses an approximate 15 mile radius around the proposed facility. The boundaries of the market area of are as follows:

- North approximately 30 minutes normal travel time to Bellwood, IL
- Northeast approximately 30 minutes normal travel time to 79th St & I-94, Chicago, IL
- East approximately 30 minutes normal travel time to 103rd St & I-94, Chicago, IL
- Southeast approximately 30 minutes normal travel time to South Holland, IL
- South approximately 30 minutes normal travel time to Matteson, IL
- Southwest approximately 30 minutes normal travel time to Lockport, IL
- West approximately 30 minutes normal travel time to Bolingbrook, IL
- Northwest approximately 30 minutes normal travel time to Downers Grove, IL

The purpose of this project is to improve access to life sustaining dialysis to residents of the community of Chicago Ridge and the immediately surrounding areas. As discussed more fully above, there is not sufficient capacity within the GSA to accommodate all of Dr. Pallath's projected referrals.

3. The minimum size of a GSA is 30 minutes; however, most of the patients reside within the immediate vicinity of the proposed facility. The proposed facility is located in Worth, IL on the immediate border of the City of Chicago Ridge. The surrounding community is comprised of

Attachment – 12

approximately 30% African American and 25% Hispanic residents. Diabetes and hypertension (high blood pressure) are the two leading causes of CKD and ESRD.¹⁰ Due to socioeconomic conditions, these populations exhibit a higher prevalence of obesity, which is a driver of diabetes and hypertension. Hispanic and African Americans are at an increased risk of ESRD compared to the general population due to the higher prevalence of these conditions in the Hispanic and African American communities. In fact, the ESRD incident rate among the Hispanic population is 1.5 times greater than the non-Hispanic population, and the ESRD incident rate among African Americans is 3.6 times greater than the non-Hispanic white population. See Attachment – 12B. This, coupled with the aging population, is expected to increase utilization. As shown in Appendix 1, the projected referrals by Dr. Pallath confirm this. Dr. Pallath expects approximately 113 of the current CKD patients to require dialysis within the next 12 to 18 months.

4. Source Information

Illinois Health Facilities and Services Review Board, Update to Inventory of Other Health Services (April 23, 2014) available at http://hfsrb.illinois.gov/hfsrbinvent_data.htm (last visited May 13, 2014).

U.S. Census Bureau, American FactFinder, Fact Sheet, available at <http://factfinder2.census.gov/faces/nav/jsf/pages/index.xhtml> (last visited May 13, 2013).

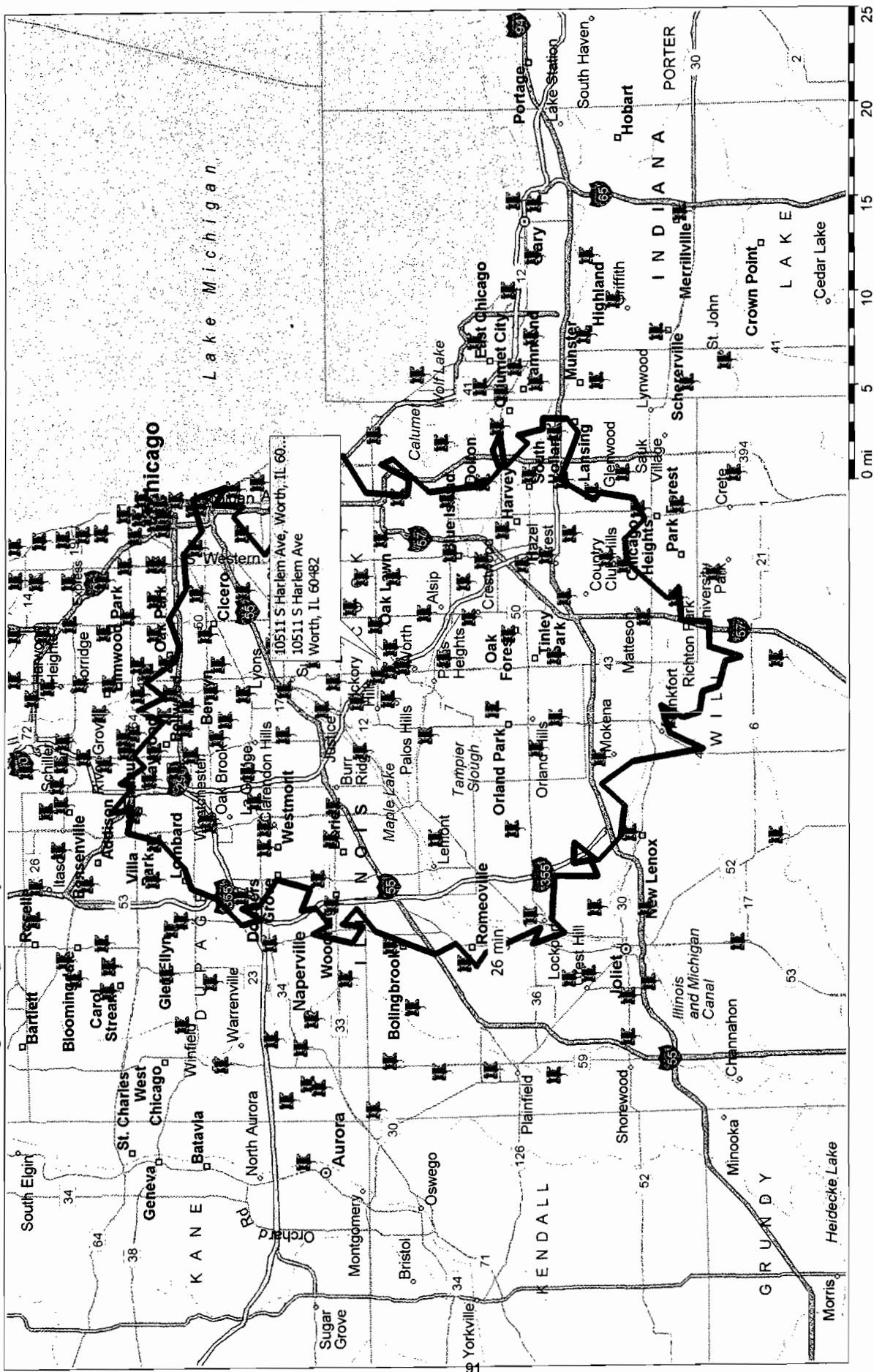
US Renal Data System, USRDS 2013 Annual Data Report: Atlas of Chronic Kidney Disease and End-Stage Renal Disease in the United States, National Institutes of Health, National Institute of Diabetes and Digestive and Kidney Diseases, Bethesda, MD; 2013.

US Renal Data System, USRDS 2011 Annual Data Report: Atlas of Chronic Kidney Disease and End-Stage Renal Disease in the United States, Bethesda, MD: National Institutes of Health, National Institute of Diabetes and Digestive and Kidney Diseases; 2011

5. The proposed facility will improve access to dialysis services to the residents Chicago Ridge community and the surrounding area by establishing the proposed facility. Given the increasing size of Dr. Pallath's patient-base, this facility is necessary to ensure sufficient access to dialysis services in this community.
6. The Applicants anticipate the proposed facility will have quality outcomes comparable to its other facilities. Additionally, in an effort to better serve all kidney patients, DaVita believes in requiring all providers measure outcomes in the same way and report them in a timely and accurate basis or be subject to penalty. There are four key measures that are the most common indicators of quality care for dialysis providers - dialysis adequacy, fistula use rate, nutrition and bone and mineral metabolism. Adherence to these standard measures has been directly linked to 15-20% fewer hospitalizations. On each of these measures, DaVita has demonstrated superior clinical outcomes, which directly translated into 7% reduction in hospitalizations among DaVita patients, the monetary result of which is more than \$1.5 billion in savings to the health care system and the American taxpayer from 2010 - 2012.

¹⁰ Michael F. Flessner, M.D., PhD et al., *Prevalence and Awareness of CKD Among African Americans: The Jackson Heart Study*, 53 Am. J. Kidney Dis. 183, 238-39 (2009), available at [http://www.ajkd.org/article/S0272-6386\(08\)01575-8/fulltext](http://www.ajkd.org/article/S0272-6386(08)01575-8/fulltext) (last visited Oct. 5, 2011).

Chicago Ridge Dialysis 10511 South Harlem Avenue, Worth, IL 60482





NIH Public Access

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Chronic Kidney Disease in United States Hispanics: A Growing Public Health Problem

Claudia M. Lora, MD, Martha L. Daviglus, MD, PhD, John W. Kusek, PhD, Anna Porter, MD, Ana C. Ricardo, MD, MPH, Alan S. Go, MD, and James P. Lash, MD

University of Illinois at Chicago, Department of Medicine, Section of Nephrology (CML, AP, ACR, JPL); Division of Research, Kaiser Permanente of Northern California and University of California, San Francisco (ASG); Department of Preventive Medicine, Northwestern University Feinberg School of Medicine (MLD); National Institutes of Health, National Institute of Diabetes and Digestive and Kidney Diseases, National Institutes of Health (JWK).

Abstract

Hispanics are the fastest growing minority group in the United States. The incidence of end-stage renal disease (ESRD) in Hispanics is higher than non-Hispanic Whites and Hispanics with chronic kidney disease (CKD) are at increased risk for kidney failure. Likely contributing factors to this burden of disease include diabetes and metabolic syndrome, both are common among Hispanics. Access to health care, quality of care, and barriers due to language, health literacy and acculturation may also play a role. Despite the importance of this public health problem, only limited data exist about Hispanics with CKD. We review the epidemiology of CKD in US Hispanics, identify the factors that may be responsible for this growing health problem, and suggest gaps in our understanding which are suitable for future investigation.

Keywords

Chronic Kidney Disease; Hispanics; Health Care Disparities

Introduction

Between 2004 and 2005, the number of Hispanic in the United States grew by 3.6 percent to reach a total of 42.7 million (representing nearly 15% of the total US population), making this the fastest growing segment of the population in the country.¹ A large increase has also occurred in the Hispanic end stage renal disease (ESRD) population. According to United States Renal Data System (USRDS), in 2005, there were 12,000 new cases of ESRD treated with dialysis or transplant in Hispanics, representing an increase of 63% since 1996. Hispanics have an incidence rate of ESRD which is 1.5 times greater than for non-Hispanics Whites.² This increase in ESRD cases not only translates into an increased burden to our health care system, but also emphasizes the importance of better understanding risk factors

Address correspondence and reprint requests to Claudia M. Lora, MD: Section of Nephrology; Department of Medicine; University of Illinois at Chicago; 820 South Wood Street (M/C 793); Chicago, Illinois 60612-7315; 312-996-6736; 312-996-7378 (fax); Cloral@uic.edu.

AUTHOR CONTRIBUTIONS *Design concept of study:* Lora, Lash

Acquisition of data: Lora, Daviglus, Kusek, Porter, Ricardo, Go, Lash

Data analysis and interpretation: Lora, Daviglus, Kusek, Porter, Ricardo, Go, Lash

Manuscript draft: Lora, Lash

Administrative, technical, or material assistance: Lora, Daviglus, Kusek, Porter, Ricardo, Go, Lash

Supervision: Lora, Lash

for chronic kidney disease (CKD) in Hispanics. In this review, we examine the epidemiology of CKD in US Hispanics, explore potential reasons for this growing public health problem, and highlight potential areas for future research.

Methods

We performed a qualitative review of the literature utilizing a PubMed search for the following keywords: chronic kidney disease, Hispanics, Latinos, end stage renal disease, diabetes, dialysis, transplantation, and health care disparities. In addition, we reviewed data from the USRDS^{2,3} and the Organ Procurement and Transplantation Network.⁴ For the purpose of this review, the term Hispanic ethnicity refers to all persons of Latin American origin living in the United States, unless indicated otherwise. Hispanics are culturally, socioeconomically, and genetically heterogeneous and represent a wide variety of national origins and social classes.⁵ In terms of ancestry, US Hispanics originate from three populations: European settlers, Native Americans, and West Africans. The breakdown for the US Hispanic population is as follows: 64% Mexican, 9% Puerto Rican, 3.5% Salvadoran and 2.7% Dominican.¹ The remainder is of Central American, South American or other Hispanic or Latino origin.

Epidemiology of CKD in Hispanics

Glomerular filtration rate (GFR) estimating equations have been used to determine the prevalence of CKD in the United States. The abbreviated Modification of Diet in Renal Disease (MDRD) equation has been considered to be the most accurate available estimating equation for GFR and has been used widely in the literature and by a growing number of clinical laboratories.⁶ Though the equation has been demonstrated to have validity across a spectrum of different subgroups,⁷ there are no data regarding its validity in Hispanics. This is a relevant concern because the serum creatinine concentration, which is used in the MDRD equation to calculate estimated GFR (eGFR), has been demonstrated to differ by racial/ethnic groups. In an analysis of serum creatinine levels in the National Health and Nutrition Examination Survey (NHANES) III, Mexican Americans had lower mean serum creatinine levels than non-Hispanic Whites or non-Hispanic Blacks.⁸ The reasons for these differences are unknown. Similarly, a recent NHANES analysis of serum cystatin C, a potentially more sensitive marker of early kidney dysfunction than serum creatinine, reported lower levels of cystatin C in Mexican Americans compared with other racial/ethnic groups studied.⁹ These differences in the distribution of serum creatinine and cystatin C levels in Hispanics reinforce the importance of rigorously evaluating the accuracy of GFR estimating equations in Hispanics.¹⁰

Incidence and Prevalence of CKD in Hispanics

Mild to Moderate CKD

Information regarding earlier stages of CKD in Hispanics is limited. Several investigators have reported a higher prevalence of microalbuminuria in Hispanics compared with non-Hispanic Whites.^{11–13} In contrast to these findings, a recent analysis of NHANES III data suggests that the prevalence of CKD may be lower in Mexican Americans than in non-Hispanic Whites or non-Hispanic Blacks. In an analysis of NHANES III, moderately decreased kidney function (eGFR 30–59 mL/minute/1.73 m²) was most prevalent among non-Hispanic Whites (4.8%) and non-Hispanic Blacks (3.1%) and least prevalent in Mexican Americans (1.0%).¹⁴ Between NHANES 1988 to 1994 and 1994 to 2004, the prevalence of CKD rose among Mexican Americans but continued to be lower than that observed in non-Hispanic Whites and Blacks.¹⁵

These data are not consistent with the higher prevalence rates of ESRD in Hispanics. One potential explanation is that Hispanics have a higher risk of ESRD because of more rapid progression of CKD after its onset, rather than simply a larger pool of individuals with CKD. The findings could also be related to methodological issues related to the sample size or sampling bias. Furthermore, as discussed earlier, the validity of the MDRD equation has not been established in Hispanics and utilizing the equation in Hispanics could be an important potential source of error. Lastly, NHANES includes only Mexican Americans and these findings may not be generalizable to other Hispanic subgroups.

End Stage Renal Disease (ESRD)

It is well established that Hispanics have a higher prevalence of ESRD than non-Hispanic Whites. The increased prevalence of treated ESRD in Hispanics was first recognized in the 1980s. Using data from the state of Texas, Mexican Americans were found to have an excess of ESRD compared with non-Hispanic Whites with an incidence ratio of 3.¹⁶ For diabetic ESRD, Mexican Americans had an incidence ratio of 6 compared with non-Hispanic Whites. The first study at a national level analyzed male Hispanics identified in Medicare ESRD program data files. Using common Spanish surnames to identify cases, it was found that Hispanics developed ESRD at a younger age than non-Hispanic Whites; and between 1980 and 1990, ESRD incidence rates increased more for Hispanics.¹⁷ In 1995, the USRDS began to acquire data regarding Hispanic ethnicity. In 2006, the adjusted incidence rate for ESRD in Hispanics was 1.5 times higher than for non-Hispanic Whites.² Furthermore, between 1996 and 2005, the incidence rate for Hispanics increased by 63%.² In contrast, Burrows et al examined trends in age-adjusted ESRD rates and reported that the age-adjusted ESRD rate in Hispanics decreased by approximately 15%, from 2000 to 2005 (530.2 vs 448.9).¹⁸ However, there was an overall increase in the age-adjusted incidence rates in Hispanics in 2005 as compared with 1995 (448.9 vs 395.0). It is apparent that a longer period of follow-up time is needed to better characterize trends. The leading causes of ESRD requiring dialysis in Hispanics and non-Hispanic Whites are described in Table 1. Diabetes accounts for 59% of prevalent cases of ESRD in Hispanic compared with 39% of cases in non-Hispanic Whites.³ Unfortunately, data regarding causes of ESRD by Hispanic subgroup are not available.

The incidence and severity of diabetes are important factors in the excessive incidence of diabetic ESRD observed in Hispanics. The prevalence of diabetes in Hispanics has been estimated to be approximately 1.5 to 3 times that seen in the non-Hispanic White population and its incidence is rising.¹⁹ Moreover, Hispanics have been found to have lower rates of glucose self-monitoring and poorer glycemic control compared with non-Hispanic Whites.²⁰ Hispanics with diabetes may be at increased risk to develop diabetic nephropathy. Mexican American diabetics in San Antonio, Texas had a higher prevalence of proteinuria than non-Hispanic White diabetics from Wisconsin.²¹ However, no such difference was observed in the San Luis Valley.²² The importance of non-diabetic CKD in Hispanics is not completely understood. Though hypertension is less prevalent in Hispanics, Mexican Americans had the highest rate of uncontrolled hypertension in NHANES III.²³ Data from Texas and the USRDS demonstrate a higher incidence of ESRD due to hypertension in Hispanics than in non-Hispanic Whites.^{16,24}

Progression of CKD in Hispanics

Only limited information is available regarding progression rates and risk factors for CKD in Hispanics. In a multivariable retrospective analysis of a cohort of 263 type 2 diabetic ESRD patients, Mexican ethnicity and female sex were found to hasten the decline of renal function.²⁵ A post hoc analysis of the Reduction of Endpoints in NIDDM with the Angiotensin II Antagonist Losartan Study (RENAAL) found that Hispanics had the highest

risk for ESRD compared with Blacks and Whites.²⁶ However, the majority of Hispanics in this study were from Latin American countries and therefore, the findings may not be applicable to US Hispanics. A recent analysis of patients enrolled in Kaiser Permanente of Northern California, a large integrated healthcare delivery system, has clarified the risk of ESRD in US Hispanics with CKD.²⁷ In 39,550 patients with stage 3 to 4 CKD, Hispanic ethnicity was associated with almost a two-fold increased risk for ESRD when compared with non-Hispanic Whites. This increased risk was attenuated to 33% after adjustment for diabetes, medication use, and other characteristics. Thus, the risk for progression to ESRD in Hispanics is only partially explained by diabetes.

Even less is known about progression rates and risk factors for non-diabetic CKD in Hispanics. Some reports suggest that certain glomerular diseases may be more severe and progress more often in Hispanics than in non-Hispanic Whites.^{28–30} In a recent examination of rates of progression in 128 patients with proliferative lupus nephritis, Barr et al. found that Hispanic ethnicity was independently associated with progression of CKD.³⁰ Another study examining patients with lupus found that Texan-Hispanic ethnicity was more likely to be associated with nephritis than Puerto Rican ethnicity.³¹ This suggests that outcomes can vary by Hispanic subgroup.

US Hispanics have been poorly represented in large prospective CKD studies. The ongoing NIDDK-sponsored Hispanic Chronic Renal Insufficiency Cohort Study (HCRIC) is investigating risk factors for CKD and cardiovascular disease (CVD) progression in a cohort of 326 Hispanics with CKD. This study is based at the University of Illinois at Chicago and is an ancillary study to the NIDDK-sponsored CRIC Study.³²

Metabolic Syndrome and CKD

Recent analyses of NHANES III data found that metabolic syndrome affects over 47 million Americans and that the problem is more pronounced in Hispanics.^{33,34} Mexican Americans have the highest age-adjusted prevalence of metabolic syndrome (31.9%) compared with non-Hispanic Whites (23.8%) and Blacks (21.6%).³³ There is now emerging evidence supporting a relationship between metabolic syndrome and CKD.^{35–38} In a prospective cohort study of Native Americans without diabetes, metabolic syndrome was associated with an increased risk for developing CKD.³⁹ In non-diabetic subjects with normal kidney function enrolled in the Atherosclerosis Risk in Communities Study (ARIC), investigators found an adjusted odds ratio of developing CKD in participants with metabolic syndrome of 1.43 compared with participants who did not have the syndrome.³⁸ These data suggest that metabolic syndrome could be an important factor in the Hispanic CKD population.

Disparities in Health Care and Prevalence and Progression of CKD

The importance of healthcare disparities in CKD has received increased recognition,⁴⁰ but little is known regarding the impact of healthcare disparities on health outcomes in Hispanics with CKD. It is well substantiated that there are considerable disparities in health care for Hispanics.²⁰ According to a report by the Commonwealth Fund, nearly two-thirds (65%) of working-age Hispanics with low incomes were uninsured for all or part of the year in 2000.⁴¹ Using NHANES III data, Harris evaluated healthcare access and utilization, and health status and outcomes for patients with type 2 diabetes.²⁰ Mexican Americans below age 65 years had lower rates of health insurance coverage than non-Hispanic Whites and Blacks (66% vs 91% and 89%, respectively). Furthermore, Mexican Americans with private insurance or a high school education or more were more likely to have normoalbuminuria.²⁰ The quality of care received by Hispanics may also play a role in the progression of kidney disease. Hispanics with diabetes are less likely to report having had a foot exam or glycosylated hemoglobin testing.⁴² As noted earlier, Mexican American in NHANES III had

the highest rate of uncontrolled hypertension.²³ Lastly, Ifudu et al reported that non-Whites, including Hispanics, are more likely to receive a late referral to a nephrologist for CKD management.⁴³ This study was limited by the low number of Hispanics in the analysis. These findings suggest that quality of care may play a role in the high prevalence of ESRD in this population.

Patient-centered factors may play a particularly important role for Hispanics include language, health care literacy, acculturation, social support, and trust in healthcare providers. Hispanics who are recent immigrants face a number of potential barriers to health care, including lack of familiarity with the healthcare system and language barriers. Spanish-speaking Hispanics are less likely to be insured, have access to care and use preventive health services.^{41,44} Trust in the healthcare system is another important factor because it has been found to be significantly related to adherence.⁴⁵ Doescher et al found that Hispanics reported significantly less trust in their physician than non-Hispanic Whites.⁴⁶ Finally, social support, defined as resources provided by a network of individuals or social groups, has been found to have direct effects on health status and health service utilization.⁴⁷ There have been no published studies to date focusing on patient-centered factors in Hispanics with CKD. However, it seems reasonable to speculate that these factors amplify CKD and associated CVD risk.

Cardiovascular Disease in Hispanics with ESRD and Earlier Stages of CKD

Several studies have found that Hispanics may have lower all-cause and CV mortality rates than non-Hispanic Whites.^{48–50} The term, Hispanic paradox, has been used to describe the lower than expected mortality rates despite the increased incidence of diabetes and obesity, lower socioeconomic status, and barriers to health care.⁵¹ A number of explanations have been proposed, including socio-cultural factors, ethnic misclassification, incomplete ascertainment of deaths, and the healthy migrant effect.^{36,52} In the ESRD population, Hispanics, Blacks, and Asians have a lower risk of death than non-Hispanic Whites, regardless of diabetes status.^{24,53–55} In a recent analysis of a national, random sample of hemodialysis patients, Hispanics had an adjusted 12-month mortality risk that was 25% lower than non-Hispanic Whites.⁵³ The reasons for the lower ESRD mortality rates are not completely understood, but differences in survival have been noted among Hispanic subgroups with Mexican-Americans, Cuban Americans and Hispanic-other having an increased survival advantage compared with Puerto Rican Americans.⁵⁶ These findings suggest that sociocultural or genetic differences may play a role in these lower ESRD mortality rates and demonstrating the importance of examining health outcomes in subgroups of Hispanics.

Less is known regarding CVD risk and disease in Hispanics with earlier stages of CKD. An analysis of mortality rates of adults with CKD in NHANES found no difference in CVD or all-cause mortality in Mexican Americans compared with non-Hispanic whites.⁵⁷ In contrast, Hispanic veterans with diabetic CKD experienced a lower 18-month mortality rate than non-Hispanic Whites.⁵⁸ Though Hispanics in Kaiser Permanente of Northern California had an increased rate of ESRD, Hispanic ethnicity was associated with 29% lower adjusted mortality rate and 19% lower adjusted rate of CVD events as compared with non-Hispanic Whites, even after accounting for major cardiovascular risk factors, comorbidities and use of preventative therapies.²⁷ Again, the reasons for these differences are not known.

End-State Renal Disease Care in US Hispanics

Dialysis

Analysis of USRDS data reveals that Hispanics are 1.47 times more likely than non-Hispanic Whites to have late initiation of dialysis.⁵⁹ At the start of dialysis, Hispanics tend to have slightly lower hematocrit levels and are 13% less likely to be on erythropoiesis stimulating agents compared with non-Hispanic Whites.⁶⁰ An analysis of a random sample of Medicare eligible adults on hemodialysis in 1997 revealed that, compared with non-Hispanic Whites, Hispanics on hemodialysis are more likely to be female, younger, and have diabetes.⁶¹ Hispanics tend to have higher albumin levels and similar hematocrit levels compared to non-Hispanic Whites.^{53,61,62}

Little is known about ESRD care in the United State for unauthorized immigrants. Of the 11.8 million unauthorized immigrants in the United States, more than 8.46 million are Hispanic.⁶³ The incidence rate for ESRD for this population is unknown. Many of these undocumented aliens do not receive systematic care before initiation of dialysis. The quality and availability of pre-ESRD care for unauthorized immigrants has not been systematically studied. A small study of undocumented ESRD patients initiating dialysis in New York City found that these patients had higher serum creatinine concentration and lower eGFR, higher systolic blood pressure, and greater costs for the hospitalization associated with the initiation of dialysis.⁶⁴ However, a limitation of this study was that it only included 33 Hispanics. An important issue regarding the dialysis of unauthorized immigrants is the compensation for dialysis, which varies by individual state and may limit the availability of long-term dialysis for undocumented aliens who are then forced to receive dialysis on an emergent basis only.⁶⁵ The cost of care for undocumented ESRD patients receiving dialysis on an emergent basis is 3.7 times higher than for those unauthorized immigrants receiving long-term maintenance dialysis.⁶⁶ End-stage renal disease in unauthorized immigrants is of great public health and economic concern and warrants future research and re-evaluation of current policies.

Transplantation

Limited data exist that suggest that Hispanics are equally likely to be referred for renal transplantation but are less likely to progress beyond the early stages of the transplant evaluation with some of the reasons including financial concerns, fear of the surgery, and preference for dialysis.⁶⁷ Perhaps for this reason, Hispanics are underrepresented on kidney waiting lists relative to the prevalence of CKD in this population.⁶⁸ Once placed on the transplant wait list, Hispanics have a longer unadjusted median time to transplant than non-Hispanic Whites.⁴ Factors that potentially contribute to the longer time on the wait list include lower rates of organ donations in Hispanics relative to Whites,^{69,70} less knowledge and more fear-related barriers to living organ donation,⁷¹ and ethnic differences in the frequency of HLA alleles coupled with current allocation policies.⁷² Data regarding graft survival in Hispanics have not been uniform, with some studies suggesting that Hispanics and non-Hispanic Whites have similar rates of graft survival,^{73,74} while other studies have demonstrated poorer rates of graft survival in Hispanics.⁷⁵ More recently, Gordon et al found better patient and graft survival in Hispanics compared with non-Hispanics.⁷⁶ Further studies are needed to clarify whether Hispanic ethnicity influences post-transplant outcomes. In addition, policies are needed to address specific barriers within the transplant evaluation process for Hispanics to ensure appropriate access to this important therapy.

Conclusion

Chronic kidney disease is a growing and under-recognized health problem for US Hispanics. Compared with non-Hispanics Whites, Hispanics have an increased incidence of ESRD that appears independent of known clinical risk factors. Furthermore, among patients starting at the same level of CKD, Hispanics are at increased risk for progression to ESRD.

Interestingly, data from NHANES suggest that the prevalence of CKD with decreased eGFR, at least in Mexican Americans, is lower than in non-Hispanic Whites. The reason for this discrepancy is unclear but could be related to more rapid progression of CKD. Many questions remain unanswered including: factors influencing CKD progression and CVD outcomes; the validity of current GFR estimating equations; insights into differences in outcomes among Hispanic subgroups; and the impact of health care disparities on CKD. For these reasons, future research is needed to better understand the epidemiology and complications of CKD in US Hispanics. Furthermore, it is essential that adequate numbers of US Hispanics are included in future interventional trials to provide the necessary evidence base to guide prevention and therapeutic strategies for CKD and ESRD.

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Hispanics have an incidence rate of ESRD which is 1.5 times greater than for non-Hispanics Whites.²

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Compared with non-Hispanics Whites, Hispanics have an increased incidence of ESRD that appears independent of known clinical risk factors.

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Table 1

Leading causes of ESRD requiring dialysis in Hispanics and non-Hispanic Whites in 2000³

Primary disease	Hispanics	Non-Hispanic Whites
Diabetes	58.8%	38.8%
Hypertension/large vessel disease	16.2%	23.7%
Glomerulonephritis	9.1%	9.9%
Etiology uncertain	3.5%	4.0%
Other	12.4%	23.6%

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Obesity and Risk for Chronic Renal Failure

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Few large-scale epidemiologic studies have quantified the possible link between obesity and chronic renal failure (CRF). This study analyzed anthropometric data from a nationwide, population-based, case-control study of incident, moderately severe CRF. Eligible as cases were all native Swedes who were aged 18 to 74 yr and had CRF and whose serum creatinine for the first time and permanently exceeded 3.4 mg/dl (men) or 2.8 mg/dl (women) during the study period. A total of 926 case patients and 998 control subjects, randomly drawn from the study base, were enrolled. Face-to-face interviews, supplemented with self-administered questionnaires, provided information about anthropometric measures and other lifestyle factors. Logistic regression models with adjustments for several co-factors estimated the relative risk for CRF in relation to body mass index (BMI). Overweight (BMI ≥ 25 kg/m²) at age 20 was associated with a significant three-fold excess risk for CRF, relative to BMI <25 . Obesity (BMI ≥ 30) among men and morbid obesity (BMI ≥ 35) among women anytime during lifetime was linked to three- to four-fold increases in risk. The strongest association was with diabetic nephropathy, but two- to three-fold risk elevations were observed for all major subtypes of CRF. Analyses that were confined to strata without hypertension or diabetes revealed a three-fold increased risk among patients who were overweight at age 20, whereas the two-fold observed risk elevation among those who had a highest lifetime BMI of >35 was statistically nonsignificant. Obesity seems to be an important—and potentially preventable—risk factor for CRF. Although hypertension and type 2 diabetes are important mediators, additional pathways also may exist.

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The number of patients with chronic renal failure (CRF) and ESRD is increasing steadily worldwide (1,2). Although the growing population with ESRD may be explained partly by more complete registration and better survival, a true rise in CRF incidence seems to be indisputable (3). This development parallels a rise in obesity prevalence of almost epidemic proportions.

Obesity has been implicated as a possible risk factor for microalbuminuria in individuals with hypertension and diabetes (4–6), and body mass index (BMI) was positively associated with progression of IgA glomerulonephritis in a cohort study (7). Studies from the general population suggest that obesity also may be harmful to the kidneys in individuals without hypertension, diabetes, or preexisting renal disease (8,9). In the Framingham Offspring cohort (10), body mass was positively related to the odds of having a GFR in the fifth or lower percentile after long-term follow-up. Similarly, follow-up among participants in health screening programs in the United States (11) and Japan (12) demonstrated a significant positive relationship between BMI and risk for ESRD, although this

association seemingly was confined to men in the Japanese study.

The aim of this study was to investigate the possible effects of body mass on the incidence of moderately severe CRF overall and by subtype. We obtained detailed anthropometric information in a nationwide, population-based, case-control study of incident preuremic CRF (13).

Materials and Methods

Study Participants

The study design has been described elsewhere (13). Briefly, the Swedish National Population Register provided a well-defined source population of 5.3 million native Swedes who were aged 18 to 74 yr and lived in Sweden during the ascertainment period, May 20, 1996, through May 31, 1998.

Eligible as cases were all men and women whose serum creatinine level, for the first time and permanently, exceeded 3.4 mg/dl (300 μ mol/L) and 2.8 mg/dl (250 μ mol/L), respectively. For ensuring complete case ascertainment, all medical laboratories that covered inpatient and outpatient care in Sweden provided monthly lists of patients who had undergone serum creatinine testing any time during the entire study period. A second creatinine measurement, 3 mo after the first, was done to verify the chronicity. Local physicians who treat patients with renal diseases determined patients' eligibility for the study by reviewing the medical records of patients with elevated serum creatinine levels. The diagnosis of underlying disease was based on the results of routine clinical evaluation. Patients with prerenal (e.g., severe heart failure) or postrenal (e.g., outlet obstruction) causes or with kid-

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ney transplants were ineligible. Of eligible cases, 16% refused or were too severely disabled to participate, and 6% had died, leaving 926 (78%) participants.

Control subjects, who were frequency-matched to cases according to age (± 10 yr) and gender, were randomly selected from the 5.3 million Swedes in the study base, using the nationwide National Population Register. The control selection was carried out on three occasions during the ascertainment period. Of 1330 selected control subjects, 998 (75%) participated, 17% refused, 4% could not be reached, and 4% were too sick to participate. All study participants provided informed consent, and the regional ethics committees and Swedish Data Inspection Board approved the study protocol.

Data Collection

Study participants completed a mailed questionnaire about anthropometric measures (height; current weight; weight at ages 20, 40, and 60; and highest weight during lifetime), education, alcohol consumption, and tobacco use. During a subsequent face-to-face interview, professional interviewers from Statistics Sweden double-checked the questionnaires and obtained information on medical history, occupation, and analgesic use. Although blinding of the interviewers to case/control status of the participants was impossible, the interviewers were instructed to interact similarly with case patients and control subjects in a standardized manner.

Data Analyses

Relative risk for CRF among groups with different anthropometric measures was estimated by odds ratios (OR) and 95% confidence intervals (CI) that were derived from unconditional logistic regression models. We analyzed data stratified by gender throughout, except in

analyses of disease-specific CRF, as a result of small sample sizes. Continuous variables (BMI [body weight divided by height raised to the second power, kg/m^2], cumulative number of cigarette pack-years, grams of alcohol per week) were categorized into quartiles according to the distribution among control subjects. In addition, BMI was categorized according to World Health Organization's (WHO's) definitions of overweight and obesity (14). Because few participants had a BMI $>30 \text{ kg}/\text{m}^2$ at age 20, BMI at that age was dichotomized into <25 and $\geq 25 \text{ kg}/\text{m}^2$. Level of education was categorized into ≤ 9 yr, 10 to 12 yr, and ≥ 13 yr. An indicator of regular use of aspirin and paracetamol was found to control sufficiently for confounding of nonnarcotic analgesic use. Adjustment for socioeconomic status instead of number of school years did not change the risk estimates. Always included as covariates in our models were age, cumulative cigarette pack-years, grams of alcohol consumed per week, ever/never regular use of paracetamol or aspirin, and number of years of formal education. We tested for interactions but did not include any interaction terms in the final models because they were statistically insignificant. Model fit was verified with the Hosmer and Lemeshow test (15).

Results

The participating case patients are characterized with regard to renal function and underlying disease in Table 1. A majority of the patients were in the preuremic stage: 80% had a creatinine level $<4.5 \text{ mg}/\text{dl}$ ($400 \text{ }\mu\text{mol}/\text{L}$); only 6% had a predicted creatinine clearance (16) $<10 \text{ ml}/\text{min}$. Approximately one third of the patients had a diagnosis of diabetic nephropathy. The second largest group was patients with glomerulonephritis (28% of men and 16% of women), followed by renal vascular

Table 1. Participating case patients with CRF: Measures of renal function and underlying diagnosis^a

	Men (n = 597)	Women (n = 329)
Serum creatinine at inclusion (mg/dl; median [range]) ^b	3.8 (3.4 to 28)	3.2 (2.8 to 19)
Creatinine clearance (ml/min; median [range]) ^c	22 (2 to 53)	19 (3 to 35)
Diagnosis group		
diabetic nephropathy (n [%])	180 (30)	106 (32)
type 1 diabetes	75	46
type 2 diabetes	97	54
unknown	8	6
glomerulonephritis (n [%])	168 (28)	54 (16)
IgA nephropathy	55	8
no renal biopsy	40	14
unclassified on biopsy	27	15
proliferative	18	8
focal segmental sclerosis	13	3
crescentic glomerulonephritis	8	4
other	7	2
renal vascular disease (n [%])	100 (17)	39 (12)
other diagnosis (n [%])	149 (25)	130 (40)
hereditary disease	58	40
systemic disease or vasculitis	40	42
other diagnosis	23	32
unknown renal disease	28	16

^aCRF, chronic renal failure.

^bConversion factor for SI unit ($\mu\text{mol}/\text{L}$) is 88.4.

^cPredicted creatinine clearance (Cockcroft-Gault formula).

disease (17 and 12% of men and women, respectively). Mean age was 58 yr for men and 57 yr for women among both case patients and control subjects (Table 2). Compared with control subjects, case patients were on average less well educated, used more analgesics, and smoked more. The proportion of alcohol users was lower among case patients, but the mean consumption was somewhat higher. As expected, the prevalence of self-reported hypertension was high among case patients: 87% of men and 85% of women, compared with approximately 25% of male and female control subjects. Diabetes, present in slightly more than one third of the case patients, was reported by 7% of the control subjects (both genders). Current BMI was similar among case patients and control subjects, whereas mean of lifetime highest BMI was significantly higher among case patients, regardless of gender ($P < 0.001$).

OR for overall CRF in relation to BMI are presented sepa-

rately for men and women (Table 3), although no statistically significant effect modification by gender could be confirmed, neither when using quartiles as cut points for BMI categories nor when using the WHO's cut points for overweight and obesity ($P = 0.35$ and $P = 0.25$, respectively). We found a positive association of highest lifetime BMI with overall CRF risk, particularly among men (Table 3). Men in the highest quartile had a 2.3-fold increased risk (95% CI 1.6 to 3.3) compared with those in the lowest quartile. The corresponding OR was modest and statistically nonsignificant among women, but when using WHO's cut points (14), clear excesses of three-fold or greater were seen for BMI ≥ 35 kg/m² in both genders. Men and women who reported a BMI ≥ 25 kg/m² at age 20 had a significant three-fold elevated risk for CRF compared with patients with BMI < 25 kg/m². BMI at age 40 and at age 60 showed similar relationships with CRF risk as did highest

Table 2. Selected characteristics of case patients and control subjects^a

	Men		Women	
	Case Patients (n = 597)	Control Subjects (n = 653)	Case Patients (n = 329)	Control Subjects (n = 345)
Age at interview (yr; n [%])				
18 to 24	5 (1)	14 (2)	5 (2)	6 (2)
25 to 34	34 (6)	32 (5)	29 (9)	26 (8)
35 to 44	59 (10)	62 (9)	36 (11)	35 (10)
45 to 54	131 (22)	116 (18)	62 (19)	70 (20)
55 to 64	124 (21)	134 (21)	62 (19)	70 (20)
65 to 74	244 (41)	295 (45)	135 (41)	138 (40)
Education (yr; n [%])				
≤ 9	350 (59)	355 (54)	187 (57)	170 (49)
10 to 12	129 (22)	150 (23)	80 (24)	96 (28)
> 12	109 (18)	142 (22)	59 (18)	78 (23)
missing	9 (2)	6 (1)	3 (1)	1 (0)
Smoking (pack-years; n [%])				
never regular smokers ^b	216 (36)	252 (39)	156 (47)	188 (54)
≤ 6.6	61 (10)	94 (14)	18 (5)	44 (13)
6.7 to 15.9	86 (14)	85 (13)	55 (17)	47 (14)
16.0 to 27.3	96 (16)	101 (15)	60 (18)	41 (12)
> 27.3	130 (22)	117 (18)	37 (11)	24 (7)
missing	8 (1)	4 (1)	3 (1)	1 (0)
Diabetes (n [%])				
yes	206 (35)	45 (7)	123 (37)	23 (7)
no	391 (65)	608 (93)	206 (63)	322 (93)
missing	0 (0)	0 (0)	0 (0)	0 (0)
Hypertension (n [%])				
yes	518 (87)	160 (25)	279 (85)	88 (26)
no	77 (13)	488 (75)	49 (15)	257 (74)
missing	2 (0)	5 (1)	1 (0)	0 (0)
Height (cm; mean [SD])	176.9 (7.3)	177.7 (7.0)	163.8 (6.4)	164.4 (5.7)
Current BMI (kg/m ² ; mean [SD])	25.6 (4.2)	25.8 (3.5)	25.0 (5.0)	25.3 (4.1)
Highest BMI ^c (kg/m ² ; mean [SD])	28.5 (4.9)	26.8 (3.9)	28.3 (5.9)	26.7 (4.6)

^aBMI, body mass index.

^bLess than 6 mo of daily smoking in lifetime.

^cHighest BMI in lifetime.

Table 3. OR for CRF associated with BMI^a

	Men		Women	
	No. of Case Patients/Control Subjects	OR ^b (95% CI)	No. of Case Patients/Control Subjects	OR ^b (95% CI)
Highest BMI (kg/m ²) ^c				
gender-specific quartiles ^d				
Q1 (lowest quartile)	101/158	1.0 (referent)	64/81	1.0 (referent)
Q2	113/160	1.1 (0.8 to 1.6)	56/85	0.8 (0.5 to 1.3)
Q3	136/158	1.4 (1.0 to 2.0)	81/82	1.2 (0.7 to 1.9)
Q4 (highest quartile)	230/157	2.3 (1.6 to 3.3)	107/84	1.3 (0.8 to 2.1)
cut points in accordance with WHO's definition of overweight and obesity				
<25.00	129/213	1.0 (referent)	96/136	1.0 (referent)
25.00 to 29.9	265/323	1.4 (1.0 to 1.9)	115/133	1.2 (0.8 to 1.8)
30.0 to 34.9	130/79	2.7 (1.9 to 4.0)	49/46	1.4 (0.8 to 2.4)
≥35.00	56/18	4.4 (2.4 to 8.2)	48/17	3.1 (1.6 to 6.1)
BMI at age 20 (kg/m ²) ^e				
gender-specific quartiles ^f				
Q1 (lowest quartile)	94/136	1.0 (referent)	55/68	1.0 (referent)
Q2	75/130	0.9 (0.6 to 1.4)	52/75	0.9 (0.5 to 1.5)
Q3	125/142	1.3 (0.9 to 1.9)	48/72	0.8 (0.5 to 1.5)
Q4 (highest quartile)	175/138	1.9 (1.3 to 2.8)	86/72	1.4 (0.8 to 2.3)
cut points in accordance with the WHO definition of overweight				
<25.0	377/506	1.0 (referent)	211/274	1.0 (referent)
≥25.0	92/40	3.1 (2.1 to 4.8)	30/13	3.0 (1.4 to 6.1)

^aCI, confidence interval; OR, odds ratio; Q, quartile; WHO, World Health Organization.

^bAdjusted for age, education, smoking, alcohol, and use of paracetamol and salicylates.

^cHighest BMI during lifetime. Because of missing information on ≥1 covariate, 46 case patients and 53 control subjects were excluded from analyses.

^dQ1: Men <24.4, women <23.6; Q2: men 24.4 to 26.4, women 23.6 to 25.8; Q3: men 26.5 to 28.8, women 25.9 to 28.9; Q4: men >28.8, women >28.9.

^eBecause of missing information on ≥1 covariate, 222 case patients and 183 control subjects were excluded from analyses.

^fQ1: men <20.5, women <19.0; Q2: men 20.6 to 21.7, women 19.1 to 20.5; Q3: men 21.8 to 23.4, women 20.6 to 21.9; Q4: men >23.4, women >21.9.

lifetime BMI, but the relative risk estimates were less precise as a result of the smaller number of patients who had attained these ages (data not shown). However, BMI at time of interview was not significantly associated with CRF risk: Men and women with BMI of 35 kg/m² or more had adjusted OR of 1.9 (95% CI 0.8 to 4.6) and 1.2 (95% CI 0.5 to 3.3), respectively, relative to patients with BMI <25.

In analyses stratified by the presence or absence of self-reported diabetes, the elevated CRF risk with increasing maximum BMI was more pronounced among individuals with than without diabetes. However, even for men and women without diabetes, a lifetime highest BMI of 35 kg/m² or more entailed a significant OR of 2.2, relative to those with BMI <25 kg/m² (Table 4). Likewise, obesity was associated with CRF also among patients who self-reported that they had no history of clinically known hypertension. The OR for CRF among these presumably nonhypertensive patients with highest BMI ≥35 kg/m² was 2.8 (95% CI 1.0 to 8.1), relative to patients with BMI

<25 kg/m². Analyses that were confined to individuals who reported neither diabetes nor hypertension produced point estimates of similar magnitude, albeit without statistical significance (Table 4). In contrast, a statistically significant three-fold risk increase was observed among those who did not have diabetes and hypertension and who reported overweight at age 20 (Table 4).

Lifetime highest BMI was dose-dependently associated with risk for all major CRF subtypes (Table 5). The highest risk was found for diabetic nephropathy: Having a BMI of 35 kg/m² or more entailed a more than seven-fold increase in risk relative to having a BMI <25 kg/m². The association was restricted essentially to nephropathy caused by type 2 diabetes, for which the OR was 6.4 (95% CI 3.5 to 11.7) among patients with a BMI of 30 to 34.9 kg/m² and 17.7 (95% CI 8.8 to 35.4) among those with a BMI of 35 kg/m² or more compared with nonoverweight individuals. A BMI of 30 kg/m² or more was associated with a significant 2.4-fold excess in risk also for nephrosclerosis and a

Table 4. OR for CRF associated with BMI^a

	No Diabetes		No Hypertension		No Diabetes or Hypertension	
	No. of Case Patients/Control Subjects	OR ^b (95% CI)	No. of Case Patients/Control Subjects	OR ^b (95% CI)	No. of Case Patients/Control Subjects	OR ^b (95% CI)
Highest BMI in lifetime (kg/m ²) ^c						
<25	159/336	1.0 (referent)	37/293	1.0 (referent)	31/281	1.0 (referent)
25 to 29.9	274/434	1.3 (1.0 to 1.7)	58/347	1.3 (0.8 to 2.0)	44/335	1.1 (0.6 to 1.8)
30 to 34.9	104/105	2.0 (1.4 to 2.8)	19/72	1.8 (1.0 to 3.5)	10/65	1.2 (0.5 to 2.6)
≥35.0	37/28	2.2 (1.3 to 3.8)	7/13	2.8 (1.0 to 8.1)	4/11	2.1 (0.6 to 7.6)
BMI at age 20 (kg/m ²) ^d						
<25.0	413/728	1.0 (referent)	81/588	1.0 (referent)	62/559	1.0 (referent)
≥25.0	64/51	2.4 (1.6 to 3.6)	17/33	3.6 (1.8 to 7.1)	12/33	3.0 (1.4 to 6.4)

^aAnalyses are restricted to participants without self-reported diabetes and/or hypertension.^bAdjusted for age, gender, education, smoking, alcohol, and use of paracetamol and salicylates.^cCut points in accordance with the WHO definition of overweight and obesity.^dCut points in accordance with the WHO definition of overweight.

Table 5. OR among men and women for various subtypes of CRF associated with BMI

	No. of Control Subjects	Diabetic Nephropathy		Nephrosclerosis		Glomerulonephritis		Other	
		No. of Case Patients	OR ^a (95% CI)	No. of Case Patients	OR ^a (95% CI)	No. of Case Patients	OR ^a (95% CI)	No. of Case Patients	OR ^a (95% CI)
Highest BMI in lifetime (kg/m ²) ^b									
<25	349	59	1.0 (referent)	30	1.0 (referent)	58	1.0 (referent)	78	1.0 (referent)
25 to 29.9	456	90	1.2 (0.8 to 1.7)	61	1.4 (0.8 to 2.2)	99	1.3 (0.9 to 1.9)	130	1.3 (1.0 to 1.9)
30 to 34.9	125	65	2.8 (1.8 to 4.4)	32	2.4 (1.4 to 4.3)	43	2.0 (1.2 to 3.2)	39	1.5 (0.9 to 2.4)
≥35.0	35	56	7.4 (4.2 to 13.0)	12	2.8 (1.2 to 6.2)	14	2.0 (1.0 to 4.2)	22	2.0 (1.1 to 3.9)
BMI at age 20 (kg/m ²) ^c									
<25.00	780	149	1.0 (referent)	95	1.0 (referent)	154	1.0 (referent)	190	1.0 (referent)
≥25.00	53	49	5.2 (3.2 to 8.4)	18	3.0 (1.6 to 5.5)	30	3.0 (1.8 to 4.9)	25	2.1 (1.2 to 3.6)

^aAdjusted for age, gender, education, smoking, alcohol, and use of paracetamol and salicylates.^bCut points in accordance with the WHO definition of overweight and obesity.^cCut points in accordance with the WHO definition of overweight.

two-fold increase in risk for glomerulonephritis and “other renal disease.” Likewise, elevated BMI at age 20 yielded increases in risk for all major types of CRF (Table 5).

Discussion

In this population-based, case-control study of preuremic CRF, being overweight at age 20 or obese (for women being morbidly obese) at any later time was linked with an increased risk for CRF. In contrast, BMI at time of interview was not significantly related to CRF. The latter finding may be explained by weight loss among case patients as a consequence of morbidity related to the renal failure itself.

There is an accumulating body of clinical and experimental data implicating obesity as an important causative factor in renal disease (17,18), but epidemiologic data linking obesity to CRF have been scarce so far. Some studies have investigated the association between obesity and proteinuria in the general

population (8,9); however, few epidemiologic studies have quantified the possible link between obesity and established renal failure in population-based settings. Our study is one of the first large-scale, population-based investigations to identify obesity as an important risk factor in the development of renal failure. Relative risk estimates that were consistent with ours were reported in a cohort study with a smaller number of incident CRF cases (19). In a Japanese cohort that was assembled during a mass screening project in 1983, high BMI was associated with an increased risk for ESRD 17 yr later but only among men (12). There, the excess risk was comparable or slightly higher than in our study. A similar US cohort study among individuals who participated in a health testing program reported an even stronger and monotonic trend of increasing ESRD risk with increasing BMI among both men and women (11). Another US cohort study among men and women who were free of kidney disease at baseline noted a 23% in-

crease per unit BMI in the odds of falling below the fifth percentile of GFR after 18.5 yr of follow-up (10).

It is widely known that obesity markedly increases risk for diabetes and hypertension (20) and that both diabetes and hypertension are important contributors to ESRD (21,22). Not surprising, in analyses that estimated risks for specific renal diseases, we found the strongest positive association of high BMI with risk for diabetic nephropathy (related to type 2 diabetes) and the second strongest relationship with nephrosclerosis (almost all patients were reported to have hypertension as the underlying cause of this diagnosis). Nevertheless, two- to three-fold risk elevations also were observed for glomerulonephritis and "other renal diseases," although we cannot exclude some degree of misclassification because the renal diagnoses were based on biopsies in only 30%. As hypertension accompanies virtually all types of renal disease not only as a cause but also frequently as a consequence of the renal failure and because both hypertension and mild to moderate renal failure can pass unnoticed for several years, it is a limitation of our study that we were unable to establish whether any hypertension preceded the onset of the kidney disease. Specifically, we cannot exclude that some patients with glomerulonephritis and "other renal diseases" also had previous hypertension, potentially related to obesity. We chose not to adjust for hypertension in our modeling because hypertension frequently is a secondary effect of CRF, but in an attempt to elucidate further the effect of BMI on CRF risk, independent of hypertension and diabetes, we conducted analyses that were stratified on these conditions. We observed stronger associations among individuals with hypertension and/or diabetes, but excesses in risks also were seen among overweight individuals with a negative self-reported history of these conditions, at least among individuals who reported overweight at age 20. However, these analyses were based on small numbers, and the results must be interpreted cautiously. In addition, some of the patients may have had undiagnosed hypertension or diabetes.

We did not take preexisting proteinuria into consideration in this study, because confounding by proteinuria seems unlikely. It seems well established that leakage of proteins through the glomeruli, regardless of the cause, is harmful to the kidney (23,24). As obesity is the cause of glomerular leakage of proteins, proteinuria must be a link in one of the causal chains between obesity and CRF. Hence, proteinuria could be a true confounding factor only if it would be associated with obesity without being a consequence of it. It is conceivable that massive proteinuria of other causes than obesity could be associated with fluid retention, but it is inconceivable that such retention could result in BMI values of 30 or more. If proteinuria of other causes than obesity would result in reduced physical activity without a corresponding reduction in energy intake, then some weight gain also would be expected, but BMI values in excess of 30 seem implausible. Therefore, in our opinion, proteinuria is in the causal pathway between obesity and CRF and does not act as a confounder.

Focal segmental glomerulosclerosis (FSGS) and/or glomerulomegaly is seen commonly in renal biopsies from morbidly obese patients (25–27), and the development of these conditions

seems to be independent of hypertension and diabetes. The proportion of all renal biopsies that exhibited obesity-related FSGS or glomerulomegaly increased 10-fold from 1986 to 2000 in a New York clinicopathologic study (27). Although a low rate of renal biopsy may have entailed underascertainment, only 16 of our case patients had received a diagnosis of FSGS, and only one had a lifetime highest BMI that exceeded 35 kg/m².

Our finding that obesity was independently associated with increased risks for all major types of CRF agrees with the "multi-hit" hypothesis (28); that is, obesity entails an extra burden on the nephrons, which promotes the progression of renal failure. Obesity previously has been linked to the progression of existing renal disease, independent of other risk factors, but it also is an independent risk factor for proteinuria in the general population (8,9). In the latter case, obesity would act as an initiator of the process, although a preceding state of reduced number of nephrons as a result of congenital or unknown environmental and lifestyle factors cannot be excluded. Obese individuals, compared with lean, are at higher risk for developing proteinuria and CRF after unilateral nephrectomy (29). This supports the view that the coexistence of obesity and reduced number of functioning nephrons increases risk for CRF.

The BMI-CRF risk relationship seemed to be somewhat stronger—and evident in a lower BMI range—in men than in women. However, no BMI*gender interactions attained statistical significance. Therefore, the observed difference is likely to be a chance finding. However, the previous literature has provided some weak indications that a true gender difference might exist (11,12). The definition of ESRD in these studies was based mainly on the occurrence of renal replacement therapy (or death as a result of ESRD), so gender differences with regard to medical management could have introduced bias. In our study, the outcome classification was based on serum creatinine measurements in combination with evaluations by local specialists. Although different cut points were used for men and women, the inherent association among body weight, muscle mass, and serum creatinine warrants cautious interpretation of gender differences. In general, however, it seems that men have a more rapid progression rate of renal failure than women (30), possibly mediated by sex hormones, but one could speculate that differences in risk that is conferred by being overweight also may be important to this gender difference in progression rate.

The mechanisms that lead to renal damage in obesity are not completely understood. Suggested contributing factors include hyperlipidemia, hyperleptinemia, a state of low-grade inflammation, hyperfiltration caused by insulin resistance, increased sympathetic activity, and activated renin-angiotensin system (17,31).

The major strengths of our study include its population-based design deriving from a well-defined and continuously enumerated source population, the complete ascertainment of all incident CRF cases, and the relatively large sample size. Moreover, the vast majority of case patients had moderately severe renal failure, thus allaying some concern about recall

bias, reverse causation, and/or selective loss of cases with rapid disease progression. Important selection bias is unlikely owing to the fairly high and equal participation rates among case patients and control subjects. However, obese individuals, who experience considerable morbidity of various kinds, may undergo serum creatinine testing more often than the average person, raising some concern about possible detection bias. The creatinine levels that were chosen for our case definition are typically symptomatic. Therefore, the pool of asymptomatic prevalent cases that potentially could be recruited through more zealous creatinine testing is likely to be small.

Misclassification of the self-reported anthropometric measures could have influenced our results. Although self-reported information on height, current weight, weight at age 20, and birth weight is known to be relatively accurate overall (32–34), there is a systematic tendency for overweight individuals to underestimate their body size; conversely, very lean individuals tend to overestimate (35). Such misclassification of exposure, if nondifferential between case patients and control subjects, would bias estimates of associations toward null. The absence of any widespread preconceptions among the public about links between anthropometric measures and CRF lessens concern about reporting bias.

Conclusion

Taking experimental, clinical, and epidemiologic data together, obesity seems to be causally linked, directly or indirectly, to the development of CRF. Our results support that obesity contributes to the rapidly increasing burden of CRF in both men and women. The excess risk for CRF among obese people seems to be driven mainly by a high prevalence of hypertension and/or type 2 diabetes, but additional pathways cannot be ruled out. According to our data, the etiologic fraction (36) of all CRF that is attributable to obesity in the comparably lean Swedish population is 16% among men and 11% among women. This fraction is likely to be greater in the United States, where the general prevalence of obesity is higher. Hence, obesity probably should be put high on the list of potentially preventable causes of CRF. Moreover, promising results of weight reduction in patients with early-stage renal disease raise hopes for future secondary prevention (37).

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See related editorial, "The Enlarging Body of Evidence: Obesity and Chronic Kidney Disease," on pages 1501–1502.

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Excess Risk of Chronic Kidney Disease among African-American *versus* White Subjects in the United States: A Population-Based Study of Potential Explanatory Factors

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Abstract. African Americans experience higher rates of chronic kidney disease (CKD) than do whites. It was hypothesized that racial differences in modifiable factors would account for much of the excess risk of CKD. A cohort study of 9082 African-American and white adults of age 30 to 74 yr, who participated in the Second National Health and Nutrition Examination Survey in 1976 to 1980 and were monitored for vital status through 1992 in the Second National Health and Nutrition Examination Survey Mortality Study, was conducted. Incident CKD was defined as treated CKD cases (ascertained by linkage to the Medicare Registry) and deaths related to kidney disease. The incidence of all-cause CKD was 2.7 times higher among African Americans, compared with whites. Adjustment for sociodemographic factors decreased the relative risk (RR) to 2.49, explaining 12% of the excess risk of CKD among

African Americans. Further adjustment for lifestyle factors explained 24% of the excess risk, whereas adjustment for clinical factors alone explained 32%. Simultaneous adjustment for sociodemographic, lifestyle, and clinical factors attenuated the RR to 1.95 (95% confidence interval, 1.05 to 3.63), explaining 44% of the excess risk. Although the excess risk of CKD among African Americans was much greater among middle-age adults (30 to 59 yr of age; RR = 4.23, statistically significant) than among older adults (60 to 74 yr of age; RR = 1.27), indicating an interaction between race and age, the same patterns of explanatory factors were observed for the two age groups. Nearly one-half of the excess risk of CKD among African-American adults can be explained on the basis of potentially modifiable risk factors; however, much of the excess risk remains unexplained.

Since the late 1970s, the incidence of end-stage renal disease (ESRD) has increased at a fourfold higher rate among African-American individuals, compared with white individuals (1). Suggested explanations for this racial disparity include lower socioeconomic status among African Americans (2–6), higher prevalence and greater severity of diabetes mellitus and hypertension among African Americans (7–11), and increased inherited susceptibility of African Americans to kidney damage (12–14). In the long term, identification of susceptibility genes might lead to the development of more preventive measures for

African-American and white subjects; however, it is important to identify risk factors for African Americans that can be modified with current approaches. One set of potentially modifiable factors is represented by socioeconomic status, which is an indirect marker of suboptimal health behaviors, inadequate access to health care, and possible adverse environmental exposures (15–18). Another set of potentially modifiable factors includes complex traits such as BP and glycemic status, which are modifiable with behavior modification and pharmacotherapy.

Previous studies that sought to explain the African-American/white differences in chronic kidney disease (CKD) rates demonstrated several limitations. Some studies used case-control study designs, which limit causal inferences (4), or relied on ecologic exposure data for information that was not available at the individual level (3,7,19–21). Other studies either used study populations that were not typical of the United States (3,11,22–24) or relied on intermediate markers of kidney disease as outcomes (6). With these considerations in mind, we conducted a population-based, prospective study to determine how much of the excess risk of CKD among African Ameri-

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cans could be explained on the basis of racial disparities in potentially modifiable risk factors.

Materials and Methods

Study Design and Sample

This study was a national, nonconcurrent, population-based, cohort study, in which we analyzed how baseline risk factors in the Second National Health and Nutrition Examination Survey (NHANES II) were related to CKD in 12 to 16 yr of passive follow-up monitoring. NHANES II was a cross-sectional, multistage, probability survey of noninstitutionalized American individuals (age, 6 mo to 74 yr) that was conducted by the National Center for Health Statistics from February 1976 to February 1980 (25,26). Details of the plan, complex sampling design, responses, and data collection procedures were previously described (25). The vital status of examined adults of age 30 to 74 yr was passively determined by matching to the National Death Index and the Social Security Administration Death Master Files, using a previously described algorithm (27). Participants were also linked (on the basis of their full name, race, and date of birth) to the Medicare Registry, to determine whether they had received renal replacement therapy (*i.e.*, dialysis or kidney transplantation).

This analysis included African-American and white subjects who were 30 to 74 yr of age at the time of the baseline evaluation. Of these 9087 individuals, five who were receiving renal replacement therapy (*i.e.*, listed in the Medicare Registry) at the time of the baseline examination were excluded, as were those with missing baseline data on family income ($n = 369$) or other key variables ($n = 155$). A similar percentage of those excluded developed CKD, compared with those included in the analysis (2.2% versus 1.3%, $P = 0.16$). After exclusions, 894 African-American and 7664 white adults remained for analysis.

Data Collection

The race of the participants in NHANES II was determined by the interviewers and was classified as "white," "African American," or "other races" (25). Questions regarding participant age, gender, marital status, education, and household income were also asked during the baseline interviews. To judge the resources available to families as a function of their total income, all household incomes (assessed using income categories, to increase the response likelihood) were expressed relative to the federal poverty thresholds for equally sized households. A poverty income ratio of <1.00 is below the federal poverty level ("poor"), a poverty income ratio of 1.00 to 1.99 is at or near the poverty level ("near poor"), and a poverty income ratio of ≥ 2.00 is 200% above the federal poverty level ("not poor") (28).

Participants were also asked two questions regarding their level of physical activity in leisure and nonleisure activities, *i.e.*, (1) whether they were getting "much," "moderate," or "little" exercise for recreation and (2) whether in their usual day, aside from recreation, they were "very active," "moderately active," or "quite inactive." Individuals reporting much exercise in recreation and/or a very physically active day were classified as being "very active." Those reporting little recreational exercise and a "quite inactive" daily routine were categorized as being "inactive." All other combinations were considered to be "moderately active." The frequency of beer, wine, and liquor consumption was obtained from a food frequency questionnaire and was categorized as never, seldom (<1 time/wk), weekly (1 to 6 times/wk), or daily (≥ 1 time/d). Smoking history at baseline was used to classify participants as never, former, or current smokers.

The body mass index was calculated from the measured height (in meters) and weight (in kilograms) and was categorized as not over-

weight (<25 kg/m²), overweight (25 to 29.9 kg/m²), or obese (≥ 30 kg/m²) (29). BP was measured twice in the right arm, by using a standard mercury sphygmomanometer, with the subject seated. The mean of the two readings was used for analysis. Persons were considered hypertensive if they demonstrated a systolic BP of ≥ 140 mmHg or a diastolic BP of ≥ 90 mmHg or if they reported being told by a doctor that they had hypertension. Persons who responded affirmatively to the question, "Has a doctor ever told you that you had diabetes?" were classified as having diabetes mellitus. A history of cardiovascular disease (CVD) was defined on the basis of a self-report of previous heart failure, heart attack, or stroke.

Total serum cholesterol levels were measured according to the protocol described for the Lipid Research Clinics Program (30). Serum creatinine determinations were performed by using the Jaffe reaction, and GFR were estimated by using the Cockcroft-Gault creatinine clearance equation (31). Because the nonresponse rate for serum creatinine levels was 28%, these measurements were considered only in subsidiary analyses (25).

Ascertainment of Outcomes

Incident all-cause CKD was defined as either treatment for ESRD or death related to kidney disease. Treated ESRD cases from February 1976 through December 31, 1992, were ascertained from the Medicare ESRD Registry, by matching participants in NHANES II on the basis of their full name, birth date, gender, and race. Those who were matched to the registry perfectly or nearly perfectly with respect to all of the matching factors were classified as definite matches ($n = 33$), whereas those with slight differences with respect to any of the matching factors were classified as probable matches ($n = 4$). All those who did not match in multiple fields or who did not match with respect to race alone were classified as possible or poor matches ($n = 46$). In our analyses, only definite and probable matches were counted as treated ESRD events.

Kidney-related deaths were identified through 1992 in the NHANES II Mortality Study. Deaths were ascertained by using the National Death Index and the Social Security Administration Death Master Files. Decedents who were not listed in the Medicare ESRD Registry but for whom any of the following kidney-related *International Classification of Diseases* (9th Revision) codes designated the underlying or contributing cause of death were also counted as CKD events: 250.4 (diabetes mellitus with nephropathy), 274.1 (gouty nephropathy), 275.4 (nephrocalcinosis), 403 (hypertensive renal disease), 404 (hypertensive heart and renal disease), 580 to 589 (nephritis, nephrotic syndrome, or nephrosis), or 593.9 (renal disease not otherwise specified). This broad definition was used to include individuals who received Medicare-funded renal replacement therapy, those who might have received it before being enrolled in Medicare, and those who might have chosen not to initiate therapy.

Analyses

All statistical analyses accounted for the complex survey design, providing nationally representative estimates. By using weighted Poisson models in Stata 6.0 (32) and the age distribution of the entire NHANES II cohort, directly age-adjusted CKD incidence rates were calculated per 100,000 person-yr of risk. Cumulative lifetime CKD incidence rates were estimated by using a weighted life-table method, and the cumulative risks of the two race groups were compared by using log-rank tests. Baseline variables were grouped as (1) sociodemographic factors, including poverty status, educational attainment, and marital status; (2), lifestyle factors, including smoking status, physical activity, alcohol use, and body mass index; and (3) clinical

factors, including diabetes mellitus, hypertension, cardiovascular diseases, systolic BP, and serum cholesterol levels. To assess relative differences in CKD incidence rates for African Americans, compared with whites, we conducted a series of five Cox proportional-hazards model analyses with Sudaan 7.5 (33), adjusting for (1) age (continuously) and gender; (2) age, gender, and sociodemographic factors; (3) age, gender, and lifestyle factors; (4) age, gender, and clinical factors; and (5) all of the aforementioned variables simultaneously. The percentage of excess risk of CKD for African Americans that was explained by a set of risk factors was calculated by using the formula

$$\% \text{ excess risk} = \frac{RR_1 - RR_2}{RR_1 - 1}$$

where RR_1 is the relative risk (RR) of CKD for African Americans versus whites adjusted only for age and gender and RR_2 is the RR adjusted for age, gender, and the set of risk factors (34,35).

To test the robustness of the associations, three subsidiary analyses were performed. We first excluded individuals who developed CKD within the first 5 yr of follow-up monitoring, to determine whether the same associations between race and CKD were present. Next, we analyzed the subpopulation with serum creatinine measurements, adjusting for GFR. Finally, we limited the outcome to treated ESRD only. Because analyses performed with treated ESRD as the outcome yielded mostly similar results (data not shown), only analyses with the combined end point of CKD (defined as either treated ESRD or death related to kidney disease) are presented.

Results

Baseline Characteristics of the Cohort

Sociodemographic and clinical characteristics of the 8558 adults who were included in the analysis are presented in Table 1. Compared with white subjects, African-American adults were more likely to have less education, live below the federal poverty level, and be unmarried. They were also more likely to be current cigarette smokers, to be more obese, to be physically inactive, and to drink less alcohol than their white counterparts. In addition, African-American adults demonstrated higher prevalences of diabetes mellitus and hypertension than did white subjects, as well as higher mean systolic BP values and GFR.

Incident CKD

With a median follow-up period of 14 yr, we identified 172 cases of CKD. Of these, 37 patients entered the Medicare ESRD Registry and 135 died without receiving Medicare-funded renal replacement therapy. The age-adjusted incidences of all-cause CKD and treated ESRD were 2.7- and 8.9-fold higher, respectively, among African-American adults, compared with white adults (Table 2). Moreover, the age-adjusted incidence of kidney disease attributable to diabetes mellitus or hypertension was almost 12 times higher among African-American adults, compared with whites. Figure 1 presents the cumulative lifetime incidences of CKD for African Americans versus whites. African Americans demonstrated a higher cumulative risk of CKD for every age after 45 yr, compared with whites. By age 80 yr, African Americans who had not died as a result of other causes demonstrated a 9.4% cumulative risk of

Table 1. Baseline characteristics of 8558 adults of age 30 to 74 yr, in NHANES II, according to race^a

Characteristic	African American (n = 894)	White (n = 7664)
Age (yr) ^b	48.2 ± 0.5	49.3 ± 0.3
Male (%)	45.1	47.4
Sociodemographic		
education (%) ^c		
1 to 8th grade	31.1	17.3
9 to 12th grade	52.4	51.9
college or more	16.5	30.8
poverty status (%) ^c		
poor	26.9	8.3
near poor	33.2	22.4
not poor	39.9	69.4
marital status (%) ^c		
never married	7.4	4.6
no longer married	34.0	15.9
currently married	58.6	79.5
Lifestyle		
smoking status (%) ^d		
never smoked	40.8	37.9
former smoker	19.2	26.6
current smoker	40.0	35.4
physical activity (%) ^d		
inactive	13.0	9.9
moderately active	56.2	62.6
highly active	30.7	27.6
alcohol use (%) ^d		
0	43.8	36.4
<1/wk	16.6	20.8
1 to 6/wk	28.4	27.9
≥1/d	11.2	14.9
obesity (%) ^c		
thin to normal (<25 kg/m ²)	36.9	49.2
overweight (25 to 29.9 kg/m ²)	36.1	35.2
obese (≥30 kg/m ²)	27.0	15.6
Clinical		
Hypertension (%) ^c	59.5	47.0
Diabetes mellitus (%) ^c	7.0	4.0
History of CVD (%) ^c	6.5	6.1
Systolic BP (mmHg) ^{b,c}	133.0 ± 0.9	129.0 ± 0.6
Serum cholesterol level (mg/dl) ^b	219.9 ± 3.1	223.4 ± 1.1
GFR (ml/min) ^{b,c,e}	90.8 ± 1.7	87.8 ± 0.8

^a NHANES II, Second National Health and Nutrition Examination Survey; CVD, cardiovascular disease.

^b Mean ± SEM.

^c $P < 0.01$; all comparisons compare African Americans with whites.

^d $P < 0.05$.

^e Serum creatinine measurements were available for 6005 adults. GFR was calculated by using the Cockcroft-Gault equation.

developing CKD, compared with 3.8% among whites ($P < 0.001$).

Explanatory Factors for Excess Risk

To determine how much of the excess risk of CKD among African-American adults was related to potentially modifiable factors, a series of multivariate proportional-hazard analyses were performed. The base model, adjusted for age and gender only, revealed that African Americans were more than two times more likely than whites to develop CKD [RR = 2.69; 95% confidence interval (CI), 1.55 to 4.51]. Further adjustment for sociodemographic variables reduced the RR to 2.49, corresponding to an 11.8% reduction in the excess risk of African

Table 2. Incident CKD among African-American and white adults of age 30 to 74 yr, in NHANES II^a

Outcome	African Americans (n = 894)		Whites (n = 7664)	
	No. of Events	Incidence Rates (per 100,000 person-yr) ^b	No. of Events	Incidence Rates (per 100,000 person-yr) ^b
Treated ESRD ^c	12	97	25	11
Diabetic or hypertensive CKD ^d	13	83	28	7
All-cause CKD ^e	33	222	139	84

^a CKD, chronic kidney disease, defined as receipt of renal replacement therapy or death with kidney disease; ESRD, end-stage renal disease.

^b Weighted and age-adjusted using the direct method, with the NHANES II African-American and white populations combined as the standard.

^c Entry into the Medicare ESRD registry.

^d Entry into the Medicare ESRD registry with renal disease attributed to hypertension or diabetes mellitus or death resulting from hypertensive or diabetic renal disease.

^e Entry into the Medicare ESRD registry or kidney-related death.

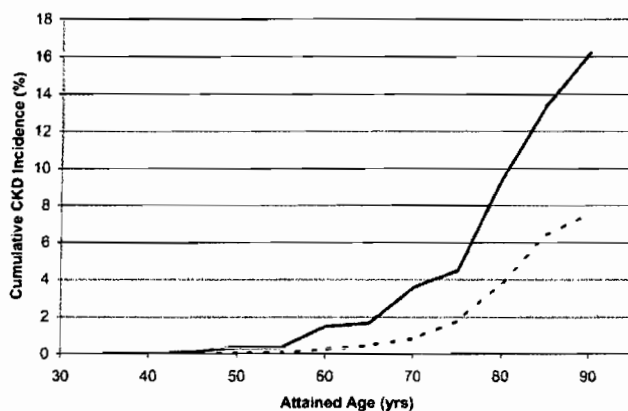


Figure 1. Cumulative incidence of chronic kidney disease (CKD), according to race and attained age, in the Second National Health and Nutrition Examination Survey (NHANES II), 1976 to 1992. Results are weighted to the general United States population. Solid line, African Americans; dashed line, whites. The cumulative incidence of CKD among African Americans was significantly higher than that among whites (log-rank test, $P < 0.001$).

Americans developing CKD (Table 3). The addition of lifestyle variables to the base model reduced the excess risk by 23.7%, whereas the addition of clinical factors to the base model substantially reduced it by 32.0% (Table 3). In fact, simply adjusting for diabetes mellitus and hypertension in the base model reduced the excess risk by 35.3% (data not shown). Simultaneously controlling for all variables yielded a 43.8% reduction in the excess risk and attenuated the RR of CKD among African Americans; however, the excess risk remained statistically significant (RR = 1.95; 95% CI, 1.05 to 3.63).

Effect Modification by Age

Testing for possible interactions between race and other variables revealed age to be a significant modifier of the association between race and CKD ($P = 0.04$). African-American adults of age 30 to 59 yr at baseline demonstrated a

Table 3. Excess risk of CKD among African Americans versus whites in relation to potentially modifiable risk factors^a

Adjusted for	RR for African Americans (versus Whites)	Excess Risk Explained (%) ^b
Age and gender only	2.69 (1.50 to 4.82)	
Sociodemographic factors ^c	2.49 (1.33 to 4.67)	11.8
Lifestyle factors ^d	2.29 (1.31 to 4.01)	23.7
Clinical factors ^e	2.15 (1.18 to 3.92)	32.0
All risk groups ^f	1.95 (1.05 to 3.63)	43.8

^a RR, relative risk. Values in parentheses are 95% confidence intervals. All models were adjusted for age and gender.

^b Calculated using the formula $(RR_{\text{age, gender}} - 1) / (RR_{\text{age, gender, factor}} - 1)$.

^c Sociodemographic factors include poverty status, education, and marital status.

^d Lifestyle factors include smoking status, body mass index, alcohol use, and physical activity.

^e Clinical factors include diabetes mellitus, hypertension, systolic BP, cardiovascular disease history, and serum cholesterol levels.

^f Adjusted for lifestyle, clinical, and sociodemographic variables.

5.4-fold higher risk of CKD, compared with whites of similar ages, whereas those of age 60 to 74 yr at baseline exhibited a RR of 1.61 (95% CI, 1.04 to 2.49), after adjustment for age and gender (Figure 2). Compared with the overall population, adjustment for lifestyle or clinical factors explained similar proportions of the excess risk among African-American adults of age 30 to 59 yr or 60 to 74 yr. In contrast, sociodemographic factors attenuated the risk among African Americans of age 60 to 74 yr by 37.7% but did not account for any excess risk of CKD among African Americans of age 30 to 59 yr. Adjustment for lifestyle and clinical factors alone explained similar percentages of the excess risk of CKD among African Americans of age 30 to 59 yr and those of age 60 to 74 yr (40.9% versus 50.8%). Simultaneous adjustment for sociodemographic, lifestyle, and clinical factors decreased the RR among African

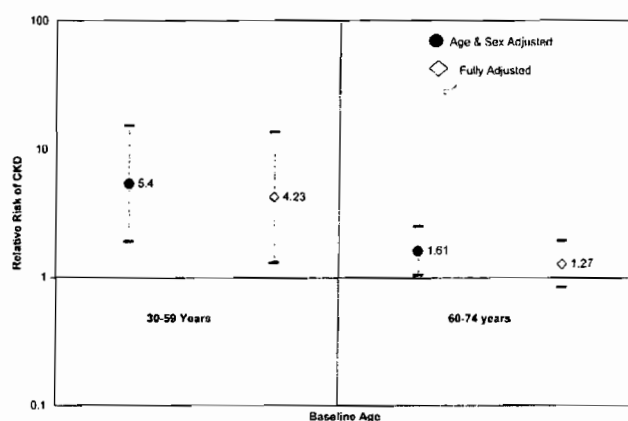


Figure 2. Adjusted relative hazard of CKD for African-American versus white adults in NHANES II, stratified according to age at baseline. All comparisons are African Americans versus whites. The fully adjusted model included age, gender, diabetes mellitus, hypertension, history of cardiovascular disease, serum cholesterol levels, smoking, poverty status, education, marital status, obesity, and alcohol use.

Americans in both age groups (Figure 2), with the racial disparity in CKD risk remaining statistically significant for the younger age group (RR = 4.23; 95% CI, 1.30 to 13.74).

Subsidiary Analyses

Further analyses of the entire cohort were performed by excluding individuals with <5 yr of follow-up monitoring, to assess the effects of early events on the observed associations between race and CKD. In these analyses, an almost identical attenuation of the excess risk among African Americans was observed after adjustment for all risk factors (39%). Finally, analyses limited to those without missing serum creatinine and urinalysis measurements, with adjustment for GFR, yielded similar patterns of percentages of excess risk explained by given sets of modifiable factors (as listed in Table 3), with the estimated risks explained being slightly higher (*i.e.*, 35% sociodemographic, 12% lifestyle, 35% clinical, and 51% all factors).

Discussion

Our results confirm that African-American adults in the United States develop CKD at rates far exceeding those for white adults, particularly during middle age. Much of the racial disparity in CKD in the United States is explained by potentially modifiable factors such as diabetes mellitus and hypertension. However, most of the excess risk of CKD experienced by African Americans remains unexplained by traditionally measured risk factors. Strengths of this study that lend weight to these conclusions include a nationally representative, population-based cohort, with comprehensive, individual-level, exposure measurements obtained before the development of CKD, and virtually complete outcome ascertainment.

Results of this study are consistent with previous findings of a higher risk of CKD among African Americans. Since 1977,

when Easterling first documented a 3.8-fold higher risk of CKD among African Americans versus whites, using the Michigan ESRD registry, there have been many studies focusing on African-American/white differences in CKD (2–11,19,23). All of those studies have documented an excess risk for African Americans, compared with whites, with estimates of the association ranging from 1.9 to 7.4. Most of those studies have been limited by reliance on data from the United States Renal Data System or other ESRD registries, which lack information on potential explanatory factors (5,7,9,10,19,36–39).

Four prospective studies used geographically aggregated measures of exposure as indirect estimates of individual-level measures (2,3,8,11). For example, Whittle *et al.* (8) used prevalence estimates of explanatory factors (such as hypertension and diabetes mellitus) obtained from a regional survey to examine the racial differences in CKD risk. They observed that adjustment for age, prevalence and severity of hypertension, diabetes mellitus, and level of education in the population reduced the risk of hypertensive ESRD in African-American areas, but the racial association remained strong and statistically significant.

Although they had individual measurements of chronic medical conditions and behaviors at baseline, Brancati *et al.* (11) and Klag *et al.* (3) lacked individual measurements of income for Multiple Risk Factor Intervention Trial screeners, which hindered accurate quantification of the effects of socioeconomic factors on the individual risk of kidney disease. Nevertheless, those groups both concluded that higher BP, lower income, and higher prevalence of diabetes mellitus and hypertension among African-American adults explained some of the racial differences in CKD risk, with a significant amount remaining unexplained.

Like Rostand *et al.* (36) and Lopes *et al.* (20,37,38), we observed that racial differences in CKD risk were modified by age, with middle-age adults (30 to 59 yr) exhibiting a greater racial disparity than older adults (60 to 74 yr). The reasons for this age interaction are unclear; however, previous authors have speculated regarding accelerated kidney damage attributable to poorer control of BP, lower potassium intake, sustained higher levels of psychologic stress, and underdeveloped kidneys (38).

In our study, the large residual excess risk observed could possibly be explained on the basis of suboptimal measurement of exposures in NHANES II. In particular, factors such as BP were measured on only one occasion, which could result in an underestimation of the strength of the attenuation between race and CKD. Additionally, better characterization of potentially modifiable risk factors such as diabetes mellitus (*e.g.*, using hemoglobin A-1c levels) might have yielded greater reductions in the excess risk. By grossly assessing socioeconomic status (using education and poverty levels), we might have inadequately adjusted for the local environment or access to and quality of health care. It is possible that these factors in combination could account for all of the residual excess risk among African Americans.

Another potential explanation for the unexplained excess risk among African Americans might be unmeasured environmental, behavioral, sociocultural, or developmental factors that were beyond the scope of NHANES II data. Literature reports suggest that undernutrition in fetal life imparts a higher risk of CKD in adulthood (40,41). Because African Americans exhibit much higher rates of low birth weights, compared with whites (42), and low birth weights are associated with kidney underdevelopment, the low birth weight theory has been advanced to help explain the racial differences in CKD rates (13). Additionally, African Americans are more likely to be exposed to occupational and environmental toxins such as lead (43), to experience viral infections (44), and to have less access to preventive medical care, as well as being referred to treatment for CKD late in the course of their disease (45). Enhanced susceptibility of African-American kidneys to injury resulting from hypertension (46,47) and racial differences in renal vascular hemodynamics (48,49) have also been cited as explanations for the racial disparity in CKD risk.

In addition to previously mentioned limitations related to the assessment of exposures, other limitations deserve comment. First, because NHANES II was restricted to the noninstitutionalized population, the absolute risks of kidney disease among whites and especially African Americans were likely underestimated (15,50,51). Second, the NHANES II Mortality Study determined vital status only for adults of age 30 to 74 yr at baseline, limiting inferences to the middle-age United States population. Third, race was determined not by self-report but by interviewer assessment, leading to potential misclassification of African Americans, Hispanics, and Native Americans as whites. A number of studies have demonstrated discrepancies between the interviewer-observed race and the self-reported race, with approximately 6% of persons self-identifying as African American being classified as white (52,53). Fourth, renal function was not assessed at baseline times for all participants. Therefore, we could not completely establish whether renal insufficiency was already present in some of the subjects who later developed CKD.

Finally, the use of passive follow-up techniques without social security numbers to determine vital status and treatment for ESRD might have led to some misclassification of outcomes. Previous studies that evaluated the effectiveness of the National Death Index and the Social Security Administration Death Master Files suggested that underascertainment of vital status occurs more commonly for African Americans than for whites (27,54,55), whereas other work proposed that there is no racial difference in ascertainment (56). Additionally, whites are more likely to have multiple causes of death coded on their death certificates (57), which could increase the ascertainment of CKD events for whites while underestimating the number for African Americans. Because the majority of our events were deaths related to kidney disease, this differential ascertainment could significantly affect our results. In addition to deaths, only individuals treated through the Medicare program were included in our analyses. Therefore, possible racial differences in enrollment in Medicare versus private insurance

could affect our findings. We might have underestimated the true racial disparity in CKD by relying on these methods. Lastly, our use of CKD attributable to any cause as the primary outcome instead of cause-specific CKD reduced the possibility of misclassification bias, which is known to be influenced by race (58,59).

In light of the exorbitant costs, to individuals and to society, of treatment for CKD, the identification of modifiable risk factors for CKD is an important public health priority, as indicated in Healthy People 2010. Our results suggest that interventions aimed at reducing the racial disparity in CKD risk should focus on primary prevention and improved treatment of diabetes mellitus and hypertension, lifestyle modification, and elimination of health disparities attributable to socioeconomic status. Our data further suggest that the benefits of these improvements might be greatest for middle-age adults. Further prospective studies are needed to identify novel environmental, developmental, and genetic causes of the large African-American/white disparity in the incidence of CKD.

Acknowledgments

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Section III, Background, Purpose of the Project, and Alternatives
Criterion 1110.230(c) – Background, Purpose of the Project, and Alternatives

Alternatives

The Applicants considered two options prior to determining to establish a 16-station dialysis facility. The options considered are as follows:

1. Utilize Existing Facilities.
2. Establish a new facility.

After exploring these options, which are discussed in more detail below, the Applicants determined to establish a 16-station dialysis facility. A review of each of the options considered and the reasons they were rejected follows.

Utilize Existing Facilities

Based upon the latest inventory data, there is a need for 86 dialysis stations in HSA 7. Based upon the ESRD Utilization Data reported to the IDPH for the quarter ending March 31, 2014, the average utilization for facilities within 20 minutes of the proposed facility is 76%, which is just below the State standard. This is not surprising given the immense size of the facility's proposed medical director's practice. Dr. Sreya Pallath's practice, J.R. Nephrology & Associates, P.C. is treating 1,084 Stage 3, 4 and 5 CKD patients, an increase of 293 patients, or 37.0%, since previously filing this application. Nearly all of these patients reside within 30 minutes normal travel time of the proposed facility. In fact, 179 Stage 4 and 5 CKD patients reside within 20 minutes of the proposed facility, an increase of 42 Stage 4 and 5 patients, or 30.7%, from our earlier application. See Appendix 1. Conservatively, based upon attrition due patient death, transplant, return of function, or relocation, Dr. Pallath anticipates that approximately 113 of these patients will initiate dialysis at the proposed facility within 12 to 24 months following project completion. (113 is an increase of 26 patients, or 29.9%, from the previously filed application.)

This facility is necessary to provide sufficient access to care for these CKD patients. Dr. Pallath's practice is currently treating ESRD patients at Stony Creek Dialysis, West Lawn Dialysis, and Beverly Dialysis, which are collectively operating at 89.5% utilization. As a result, without operating a fourth shift, these facilities cannot accommodate Dr. Pallath's already large, and growing, patient-base. This, coupled with high utilization in the service area, supports the need for a new 16-station facility.

The establishment of a 16-station dialysis facility will improve access to necessary dialysis treatment for those individuals in the Chicago Ridge community who suffer from ESRD. ESRD patients are typically chronically ill individuals and adequate access to dialysis services is essential to their well-being.

Further, the proposed project will improve access to dialysis services for the community at large by adding a much needed dialysis facility to the Chicago Ridge community. Importantly, approximately 55% of this community is either African American or Hispanic. African Americans and Hispanics are at an increased risk of ESRD compared to the general population due to the higher prevalence of diabetes and hypertension, the two leading causes of CKD and ESRD, in their communities. In fact, the ESRD incident rate among the Hispanic population is 1.5 times greater than the non-Hispanic population, and the ESRD incident rate among African Americans is 3.6 times greater than the non-Hispanic white population. As such, demand in the community will continue to increase.

Thus, because utilization of existing facilities will not meet the needs of the community, DaVita rejected this option.

There is no capital cost with this alternative.

Establish a New Facility

Based upon current utilization of the existing facilities and the projected number of CKD patients that will require in-center hemodialysis within the next 12 to 24 months following project completion, the only feasible option is to establish a 16-station in-center hemodialysis facility. This alternative will ensure residents of the Chicago Ridge community and the surrounding area have continued access to life sustaining dialysis treatment.

The cost of this alternative is \$3,494,553.

Section IV, Project Scope, Utilization, and Unfinished/Shell Space
Criterion 1110.234(a), Size of the Project

The Applicants propose to establish a 16-station dialysis facility. Pursuant to Section 1110, Appendix B of the HFSRB's rules, the State standard is 360-520 gross square feet per dialysis station for a total of 5,760 to 8,320 gross square feet for 16 dialysis stations. The total gross square footage of the proposed dialysis facility is 7,423 gross square feet (or 464 GSF per station). Accordingly, the proposed Facility meets the State standard.

SIZE OF PROJECT				
DEPARTMENT/SERVICE	PROPOSED BGSF/DGSF	STATE STANDARD	DIFFERENCE	MET STANDARD?
ESRD	7,423	5,760 – 8,320	0	State Standard Met

Section IV, Project Scope, Utilization, and Unfinished/Shell Space
Criterion 1110.234(b), Project Services Utilization

By the second year of operation, annual utilization at the proposed facility shall exceed HFSRB's utilization standard of 80%. Pursuant to Section 1100.1430 of the HFSRB's rules, facilities providing in-center hemodialysis should operate their dialysis stations at or above an annual utilization rate of 80%, assuming three patient shifts per day per dialysis station, operating six days per week. Dr. Pallath is currently treating 179 CKD patients whose condition is advancing to ESRD and who will likely require dialysis within the next 12 to 24 months following project completion. See Appendix 1. Conservatively, based upon attrition due patient death, transplant, return of function, or relocation, it is estimated that 113 of these patients will initiate dialysis within 12 to 18 months.

Table 1110.234(b) Utilization					
	Dept./ Service	Historical Utilization (Treatments)	Projected Utilization	State Standard	Met Standard?
Year 1	ESRD	N/A	14,976	11,981	Yes
Year 2	ESRD	N/A	14,976	11,981	Yes

Section IV, Project Scope, Utilization, and Unfinished/Shell Space
Criterion 1110.234(c), Unfinished or Shell Space

This project will not include unfinished space designed to meet an anticipated future demand for service. Accordingly, this criterion is not applicable.

Section IV, Project Scope, Utilization, and Unfinished/Shell Space
Criterion 1110.234(d), Assurances

This project will not include unfinished space designed to meet an anticipated future demand for service. Accordingly, this criterion is not applicable.

Section VII, Service Specific Review Criteria
In-Center Hemodialysis
Criterion 1110.1430, In-Center Hemodialysis Projects – Review Criteria

1. Planning Area Need

The Applicants propose to establish a 16-station dialysis facility to be located at 10511 South Harlem Avenue, Worth, Illinois 60482. There is currently a need for 86 dialysis stations in the service area where the proposed facility will be located. As shown in Attachment – 26A, there are currently 33 existing or approved facilities within 30 minutes normal travel time of the proposed facility. Average utilization of existing facilities within 20 minutes of the proposed Chicago Ridge Dialysis for the quarter ending March 31, 2014, is 76%, which is just below the State Board's Standard.

Importantly, the prevalence of ESRD will continue to increase for the foreseeable future. Based upon data from the U.S. Centers for Disease Control and Prevention, 10% of American adults have some level of CKD. Further, the National Kidney Fund of Illinois estimates over 1 million Illinoisans have CKD and most do not know it. Kidney disease is often silent until the late stages when it can be too late to head off kidney failure. As more working families obtain health insurance through the Accountable Care Act (or ACA)¹¹ and 1.5 million Medicaid beneficiaries transition from traditional fee for service Medicaid to Medicaid managed care,¹² more individuals in high risk groups, like low income African-Americans and Hispanics, will have better access to primary care and kidney screening. As a result of these health care reform initiatives, there will likely be tens of thousands of newly diagnosed cases of CKD in the years ahead. Once diagnosed, many of these patients will be further along in the progression of CKD due to the lack of nephrologist care prior to diagnosis. It is imperative that enough stations are available to treat this new influx of ESRD patients, who will require dialysis in the next couple of years.

Importantly, the nine months since filing the initial Chicago Ridge application, sixty additional end-stage renal disease ("ESRD") patients have initiated dialysis at centers in the Chicago Ridge service area. Further, 42 additional chronic kidney disease ("CKD") patients treated by J.R. Nephrology & Associates, P.C., the primary referring nephrology practice, have advanced to Stage 4 or Stage 5 CKD and will likely initiate dialysis within the next 24 months. (See Appendix – 1).

"Health care services should be appropriately located to best meet the needs of the population. Illinois residents needing services should not be forced to travel excessive distances." (77 Ill. Admin. Code 1100.400). While many underutilized facilities are located within the proposed Chicago Ridge's service area, 125 (or 70%) the projected patients reside in and around Oak Lawn. See Table 1110.1430 below. Therefore, not all of the facilities within Chicago Ridge's GSA are within 30 minutes of where the projected patients reside. Accordingly, FMC Elmhurst, FMC Mokena, and U.S. Renal Oak Brook, which are over 30 minutes away are not viable options for patients. See Attachment – 26B.

¹¹ According to data from the federal government 61,111 Illinois residents enrolled in a health insurance program through the ACA.

¹² In January 2011, the Illinois General Assembly passed legislation mandating 50% of the Medicaid population to be covered by a managed care program by 2015.

Projected Patients' Proximity to Oak Lawn				
Zip Code	Patients	Distance from Oak Lawn	Travel Time from Oak Lawn	Adjusted Travel Time from Oak Lawn
60453	40	0 mi	0	0
60456	5	2.26 mi	7	8
60415	3	2.61 mi	8	9
60459	10	2.91 mi	8	9
60805	10	3.06 mi	9	10
60482	3	3.48 mi	10	12
60652	20	3.65 mi	11	13
60803	10	4.06 mi	12	14
60455	5	4.74 mi	12	14
60457	6	4.75 mi	13	15
60655	13	4.76 mi	13	15
60463	6	5.81 mi	14	16
60465	2	5.53 mi	15	17
60527	2	11.61 mi	16	18
60445	7	6.54 mi	16	18
60458	4	6.62 mi	16	18
60525	2	9.95 mi	16	18
60643	9	5.83 mi	17	20
60464	2	7.39 mi	18	21
60406	1	7.57 mi	18	21
60501	3	7.85 mi	19	22
60467	3	12.88 mi	22	25
60452	4	8.94 mi	23	26
60477	5	12.05 mi	25	29
60462	4	11.57 mi	26	30
Total	179			

Requiring patients to travel more than 30 minutes for dialysis, three times per week is excessive and does not best meet the patients' need. Many of the patients to be served by the Proposed Project suffer multiple co-morbidities, are very debilitated and require transportation support. When patients must travel excessive distances, it exacerbates transportation access issues and results in missed dialysis treatments and involuntary non-compliance. Non-compliance has significant negative consequences. Skipping one or more dialysis sessions in a month has been associated with a 16% higher risk of hospitalization and 30% increased mortality risk compared to those who did not miss a dialysis session.

2. Service to Planning Area Residents

The primary purpose of the proposed project is to maintain access to life-sustaining dialysis services to the residents of the Chicago Ridge community and the surrounding area. As evidenced in the physician referral letter attached at Appendix 1, all 179 pre-ESRD patients reside within 20 minutes of the proposed facility.

3. Service Demand

Attached at Appendix 1 is a physician referral letter from Dr. Pallath and a schedule of pre-ESRD and current patients by zip code. A summary of CKD patients projected to be referred to the proposed dialysis facility within the first two years after project completion is provided in Table 1110.1430(b)(3)(B) on the following page.

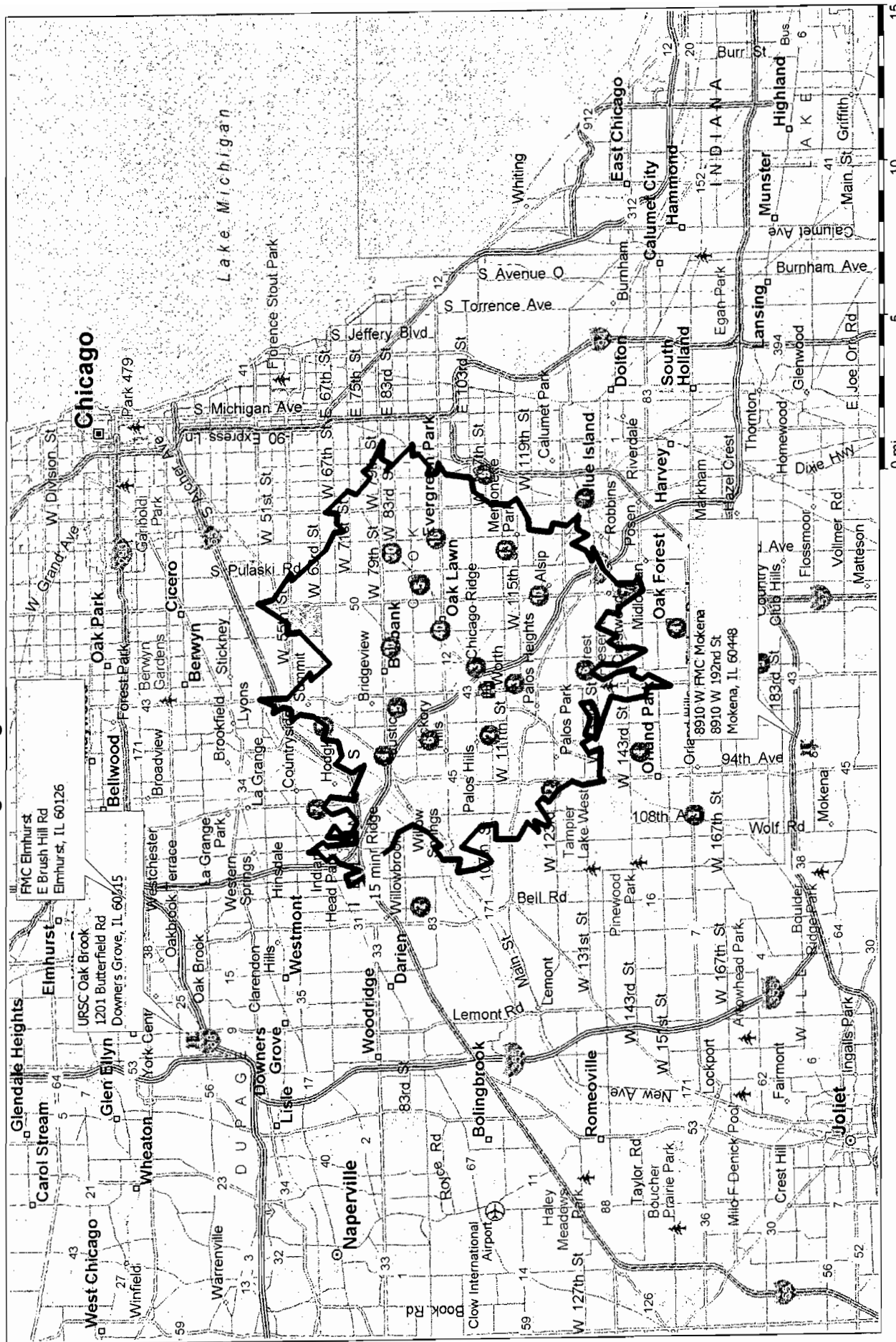
Table 1110.1430(b)(3)(B) Projected Pre- ESRD Patient Referrals by Zip Code	
Zip Code	Total Patients
60406	1
60415	3
60445	7
60452	4
60453	40
60455	5
60456	5
60457	6
60458	4
60459	10
60462	4
60463	6
60464	2
60465	2
60467	3
60477	5
60482	3
60501	3
60525	2
60527	2
60643	9
60652	20
60655	13
60803	10
60805	10
Total	179

4. Service Accessibility

As set forth throughout this application, the proposed facility is needed to maintain access to life-sustaining dialysis for residents in the Chicago Ridge community and the surrounding area. Based upon the ESRD Utilization Data reported to the IDPH for the quarter ending March 31, 2014, the average utilization of existing facilities within 20 minutes of the proposed Chicago Ridge Dialysis 76%. Moreover, HFSRB currently identifies a need for 86 stations in HSA 7. Accordingly, a new dialysis facility is needed to improve access to dialysis services to residents in the Chicago Ridge community.

End Stage Renal Disease Facility	Address	City	Distance	Time	Adjusted	3/31/2014 Stations	3/31/2014 Patients	3/31/2014 Utilization
Stony Creek Dialysis	9115 S. Cicero	Oak Lawn	4.1	10	12	12	62	86.1%
Palos Park Dialysis	13155 S. La Grange Rd.	Orland Park	5.1	10	12	12	33	45.8%
FMC Crestwood	4861-73 West Cal Sag Road	Crestwood	5.2	11	13	24	102	70.8%
FMC Alsip	12250 South Cicero Avenue	Alsip	7.1	11	13	20	75	62.5%
Mt. Greenwood Dialysis	3401 W. 111th St.	Chicago	5.5	13	15	16	79	82.3%
DSI Scottsdale	4651 W. 79th Street, Unit 100	Chicago	5.8	13	15	35	145	69.0%
FMC Burbank	4811 W. 77th Street	Burbank	6.1	14	16	26	145	92.9%
FMC Midway Dialysis	6201 W. 63rd St.	Chicago	6.6	14	16	12	71	98.6%
Concerto Dialysis (f/k/a Direct Dialysis)	14255 S. Cicero Ave.	Crestwood	6.6	14	16	7	37	88.1%
FMC Merrionette Park	11650 S. Kedzie Avenue	Merrionette Park	6.5	15	17	24	99	68.8%
West Lawn Dialysis	7000 South Pulaski Road	Chicago	7.7	17	20	12	62	86.1%
FMC - Orland Park	9160 West 159th Street	Orland Park	9.0	17	20	18	83	76.9%
FMC South Side	3134 W. 76th Street	Chicago	7.0	18	21	39	200	85.5%
FMC Oak Forest	5340A West 159th Street	Oak Forest	9.1	18	21	12	11	15.3%
Beverly Dialysis	8109 S. Western Avenue	Chicago	7.9	19	22	14	80	95.2%
FMC Blue Island	12200 Western Avenue	Blue Island	8.7	19	22	24	126	87.5%
FMC Willowbrook	6300 S. Kingery Highway	Willowbrook	13.0	19	22	20	79	65.8%
Markham Renal Center	3053 West 159th Street	Markham	13.3	19	22	24	95	66.0%
FMC Evergreen Park	9730 South Western Avenue	Evergreen Park	7.2	20	23	30	152	84.4%
NxStage Dialysis	1600 West 16th Street	Oak Brook	16.7	20	23	8	0	0.0%
Nocturnal Dialysis Spa	1634 South Ardmore Avenue	Villa Park	18.0	21	24	12	0	0.0%
FMC Marquette Park	6535 S. Western Ave	Chicago	8.9	22	25	16	88	91.7%
FMC Westchester	2400 Wolf Road, Suite 101a	Westchester	14.4	22	25	20	90	75.0%
FMC Berwyn	2601 Harlem Avenue	Berwyn	9.9	23	26	28	152	90.5%
FMC Cicero	3000 South Cicero Avenue	Cicero	11.7	23	26	16	29	30.2%
FMC Elmhurst	133 East Brush Hill Road	Elmhurst	16.1	23	26	28	102	60.7%
Community Dialysis of Harvey	16641 Halsted St.	Harvey	16.7	23	26	18	70	64.8%
FMC Chatham Dialysis	8710 S. Holland Road	Chicago	9.9	25	29	16	63	65.6%
FMC Mokena	8910 W. 192nd Street	Mokena	13.3	25	29	12	50	69.4%
FMC Hazel Crest	17524 East Carriageway Drive	Hazel Crest	16.8	25	29	16	84	87.5%
USRC Oak Brook	1201 Butterfield Road	Downers Grove	1.9	26	30	13	39	50.0%
FMC Roseland	132 W. 111 th St.	Chicago	9.7	26	30	12	72	100.0%
Lawndale Dialysis	3934 West 24th Street	Chicago	13.1	26	30	16	16	16.7%
FMC Bolingbrook	329 Remington Blvd	Bolingbrook	18.7	26	30	24	119	82.6%
Total						636	2,710	71.0%
Total - Facilities within 20 minutes						218	993	75.9%

Chicago Ridge Patient Residence



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Section VII, Service Specific Review Criteria
In-Center Hemodialysis
Criterion 1110.1430(c), Unnecessary Duplication/Maldistribution

1. Unnecessary Duplication of Services

- a. The proposed dialysis facility will be located at 10511 South Harlem, Worth, Illinois 60482. A map of the proposed facility's market area is attached at Attachment – 26C. A list of all zip codes located, in total or in part, within 30 minutes normal travel time of the site of the proposed dialysis facility as well as 2010 census figures for each zip code is provided in Table 1110.1430(c)(1)(A).

Table 1110.1430(c)(1)(A) Population of Zip Codes within 30 Minutes of Proposed Facility		
Zip Code	City	Population
60446	ROMEOVILLE	39,807
60441	LOCKPORT	36,869
60491	HOMER GLEN	22,743
60517	WOODRIDGE	32,038
60515	DOWNERS GROVE	27,503
60516	DOWNERS GROVE	29,084
60559	WESTMONT	24,852
60439	LEMONT	22,919
60561	DARIEN	23,115
60527	WILLOWBROOK	27,486
60514	CLARENDON HILLS	9,708
60521	HINSDALE	17,597
60558	WESTERN SPRINGS	12,960
60523	OAK BROOK	9,890
60181	VILLA PARK	28,836
60126	ELMHURST	46,371
60162	HILLSIDE	8,111
60163	BERKELEY	5,209
60448	MOKENA	24,423
60487	TINLEY PARK	26,928
60467	ORLAND PARK	26,046
60462	ORLAND PARK	38,723
60477	TINLEY PARK	38,161
60443	MATTESON	21,145
60478	COUNTRY CLUB HILLS	16,833
60452	OAK FOREST	27,969
60463	PALOS HEIGHTS	14,671

**Table 1110.1430(c)(1)(A)
Population of Zip Codes within
30 Minutes of Proposed Facility**

Zip Code	City	Population
60445	MIDLOTHIAN	26,057
60464	PALOS PARK	9,620
60480	WILLOW SPRINGS	5,246
60465	PALOS HILLS	17,495
60457	HICKORY HILLS	14,049
60455	BRIDGEVIEW	16,446
60525	LA GRANGE	31,168
60526	LA GRANGE PARK	13,576
60458	JUSTICE	14,428
60501	SUMMIT ARGO	11,626
60513	BROOKFIELD	19,047
60534	LYONS	10,649
60482	WORTH	11,063
60415	CHICAGO RIDGE	14,139
60459	BURBANK	28,929
60803	ALSIP	22,285
60453	OAK LAWN	56,855
60456	HOMETOWN	4,349
60638	CHICAGO	55,026
60402	BERWYN	63,448
60422	FLOSSMOOR	9,403
60430	HOMEWOOD	20,094
60429	HAZEL CREST	15,630
60428	MARKHAM	12,203
60472	ROBBINS	5,390
60469	POSEN	5,930
60406	BLUE ISLAND	25,460
60426	HARVEY	29,594
60425	GLENWOOD	9,117
60438	LANSING	28,884
60473	SOUTH HOLLAND	22,439
60419	DOLTON	22,788
60827	RIVERDALE	27,946
60655	CHICAGO	28,550
60805	EVERGREEN PARK	19,852
60652	CHICAGO	40,959

Table 1110.1430(c)(1)(A) Population of Zip Codes within 30 Minutes of Proposed Facility		
Zip Code	City	Population
60643	CHICAGO	49,952
60620	CHICAGO	72,216
60629	CHICAGO	113,916
60632	CHICAGO	91,326
60636	CHICAGO	40,916
60621	CHICAGO	35,912
60628	CHICAGO	72,202
60619	CHICAGO	63,825
60154	WESTCHESTER	16,773
60155	BROADVIEW	7,927
60104	BELLWOOD	19,038
60153	MAYWOOD	24,106
60141	HINES	224
60546	RIVERSIDE	15,668
60130	FOREST PARK	14,167
60304	OAK PARK	17,231
60804	CICERO	84,573
60623	CHICAGO	92,108
60608	CHICAGO	82,739
60616	CHICAGO	48,433
Total		2,392,989

Source: U.S. Census Bureau, Census 2010, American Factfinder
available at
<http://factfinder2.census.gov/faces/tableservices/jsf/pages/productview.xhtml?src=bkmk> (last visited June 30, 2013).

- b. A list of existing and approved dialysis facilities located within 30 minutes normal travel time of the proposed dialysis facility is provided at Attachment – 26A.

2. Maldistribution of Services

The proposed dialysis facility will not result in a maldistribution of services. A maldistribution exists when an identified area has an excess supply of facilities, stations, and services characterized by such factors as, but not limited to: (1) ratio of stations to population exceeds one and one-half times the State Average; (2) historical utilization for existing facilities and services is below the HFSRB's utilization standard; or (3) insufficient population to provide the volume or caseload necessary to utilize the services proposed by the project at or above utilization standards. As discussed more fully below, the ratio of stations to population in the GSA is 81.5% of the State average, the average utilization of existing facilities is 71%, and sufficient population exists to achieve target utilization. Accordingly, the proposed dialysis facility will not result in a maldistribution of services.

- a. Ratio of Stations to Population

As shown in Table 1110.1430(c)(2)(A), the ratio of stations to population is 81.5% of the State Average.

Table 1110.1430(c)(2)(A)			
Ratio of Stations to Population			
	Population	Dialysis Stations	Stations to Population
Geographic Service Area	2,392,989	624	1:3,834
State	12,830,632	4,105	1:3,126

b. Historic Utilization of Existing Facilities

Additionally, the average utilization for facilities within 20 minutes of the proposed Chicago Ridge Dialysis is 76%. Accordingly, there is sufficient patient population to justify the need for the proposed facility. There will be no maldistribution of services. Additional stations are necessary to adequately meet rising demand and a need of 86 additional dialysis stations, as identified by the HFSRB Inventory.

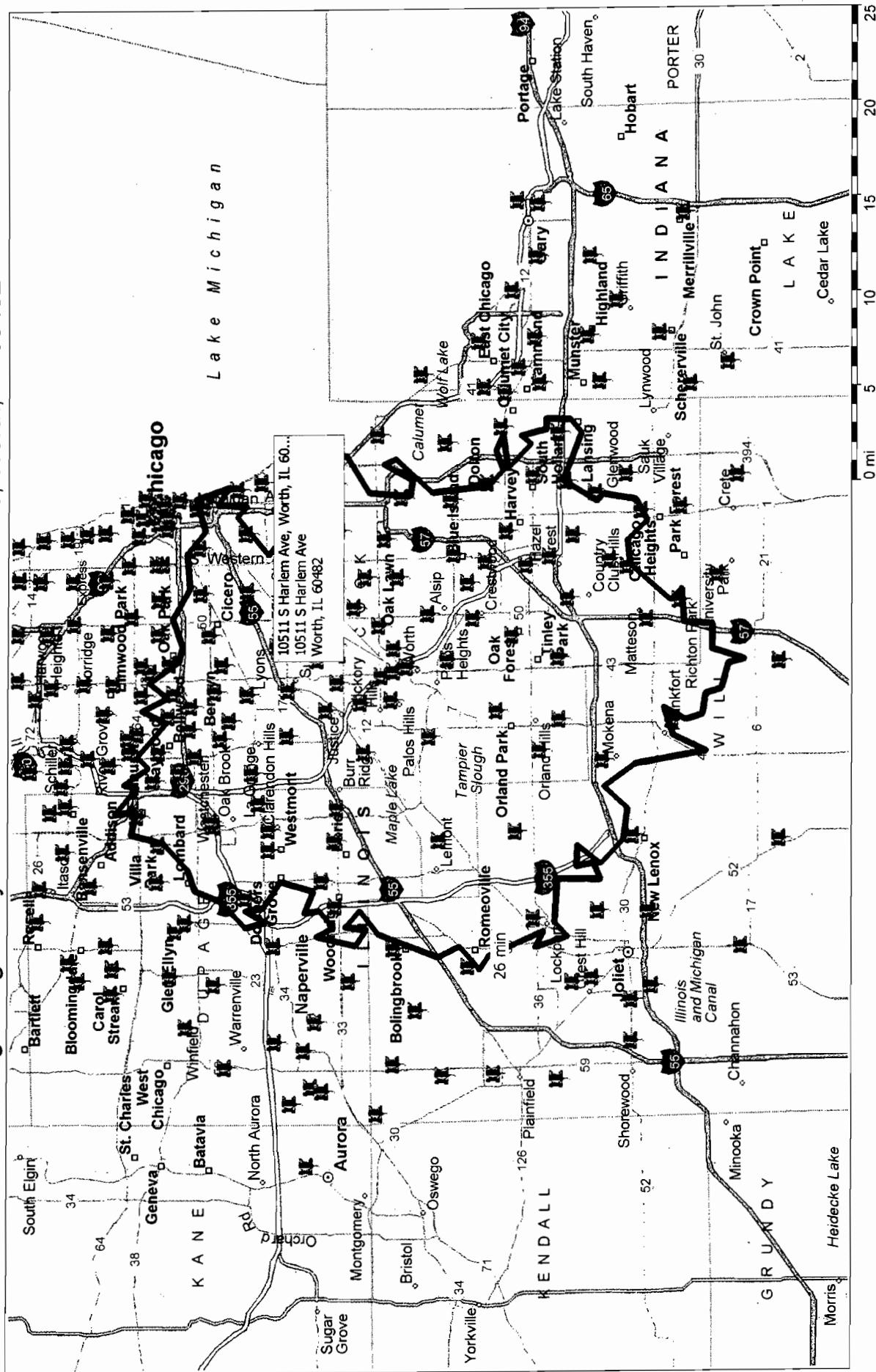
c. Sufficient Population to Achieve Target Utilization

The Applicants propose to establish a 16-station dialysis facility. To achieve the HFSRB's 80% utilization standard within the first two years after project completion, the Applicants would need 77 patient referrals. As set forth above in Table 1110.230(b)(2), Dr. Pallath is currently treating 179 CKD patients. Conservatively, based upon attrition due patient death, transplant, return of function, or relocation, it is estimated that 113 of these patients will initiate dialysis within 12 to 24 months following project completion.

3. Impact to Other Providers

- a. The proposed dialysis facility will not have an adverse impact on existing facilities in the GSA. As discussed throughout this application, the average utilization at the facilities within 20 minutes of the proposed Chicago Ridge Dialysis is 76% and the HFSRB Inventory identifies a need of 86 additional stations.
- b. The proposed facility will not lower the utilization of other area providers that are operating below the occupancy standards.

Chicago Ridge Dialysis 10511 South Harlem Avenue, Worth, IL 60482



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Section VII, Service Specific Review Criteria
In-Center Hemodialysis
Criterion 1110.1430(e), Staffing

1. The proposed facility will be staffed in accordance with all State and Medicare staffing requirements.
 - a. Medical Director: Sreya Pallath, M.D. will serve as the Medical Director for the proposed facility. A copy of Dr. Pallath's curriculum vitae is attached at Attachment – 26D.
 - b. Other Clinical Staff: Initial staffing for the proposed facility will be as follows:

Administrator
Registered Nurse (2.3 FTE)
Patient Care Technician (5.2 FTE)
Biomedical Technician (0.3 FTE)
Social Worker (licensed MSW) (0.6 FTE)
Registered Dietitian (0.6 FTE)
Administrative Assistant (1 FTE)

As patient volume increases, nursing and patient care technician staffing will increase accordingly to maintain a ratio of at least one direct patient care provider for every 4 ESRD patients. At least one registered nurse will be on duty while the facility is in operation.
 - c. All staff will be training under the direction of the proposed facility's Governing Body, utilizing DaVita's comprehensive training program. DaVita's training program meets all State and Medicare requirements. The training program includes introduction to the dialysis machine, components of the hemodialysis system, infection control, anticoagulation, patient assessment/data collection, vascular access, kidney failure, documentation, complications of dialysis, laboratory draws, and miscellaneous testing devices used. In addition, it includes in-depth theory on the structure and function of the kidneys; including, homeostasis, renal failure, ARF/CRF, uremia, osteodystrophy and anemia, principles of dialysis; components of hemodialysis system; water treatment; dialyzer reprocessing; hemodialysis treatment; fluid management; nutrition; laboratory; adequacy; pharmacology; patient education, and service excellence. A summary of the training program is attached at Attachment – 26E.
 - d. As set forth in the letter from Arturo Sida, Assistant Corporate Secretary of DaVita HealthCare Partners Inc. and Cagles Dialysis, LLC attached at Attachment – 26F, Chicago Ridge Dialysis will maintain an open medical staff.

Sreya Pallath, M.D.**Maiden Name**

Sreya Patri

Home Address

1124 Covington Drive

Lemont, IL 60439

(H) 630/685-4049

Work Address

J. R. Nephrology & Associates, P.C.

4542 West 95th Street

Oak Lawn, Illinois 60453

Tel: 708/425-0522

Fax: 708/425-4505

Email: jrnephrology@sbcglobal.net

Medical Education & Training

Fellow, Department of Nephrology

2002-2004

University of Illinois at Chicago

- Inpatient services: nephrology consultation, transplant service, medical intensive care unit, coronary intensive care unit.
- Outpatient longitudinal clinics: hemodialysis shifts, peritoneal dialysis clinic.
- Teaching responsibilities: case presentations, topic reviews, journal clubs, all with literature review; formal lectures to medical students and internal medicine residents.

Hospital Affiliations

- University of Illinois Medical Center, Chicago, IL
- V.A. Chicago Health Care System, West Side Division, Chicago, IL
- Cook County Hospital, Chicago, IL

Resident, Department of Internal Medicine

1999-2002

University of Illinois at Chicago

Education

Doctorate of Medicine

1995-1999

Rush Medical College, Chicago

Bachelor of Science

1991-1995

University of Illinois at Urbana-Champaign

- Major: Biology, Honor's; GPA: 4.5/5.0
- Dean's List 1991-1995

Credentials

Diplomate, American Board of Internal Medicine

2002-2012

U.S. Medical Licensure Examinations, Steps I-III

Licensure: Illinois

Board Certified in Nephrology

2005-2015

Publications**Gordon Syndrome - New Insights into the Pathogenetic Mechanisms**

Sreya Pallath, M.D.

Accepted for publication in: *Kidney - A current survey of world literature***BK nephropathy in lung transplantation**

Sreya Pallath, Shellee Grim, Nina Clark

Currently in writing

Research Experience**Role of angiogenesis factors on diabetic rats**

2003

Mentors: Dr. A. K. Singh, Dr. J. A. Arruda

Department of Nephrology: Cook County Hospital, Chicago

- Prepared pathologic slides with staining and immunofluorescence of granulomas specimens of subcutaneous tissue obtained from diabetic and control rats exposed to various angiogenesis factors.
- Examined the effects of these angiogenesis factors on neovascularization.

Assessment of urinary albumin using a new non-immunologic fluorescent dye

2000

Mentors: Dr. A. K. Singh, Dr. J. A. Arruda

Department of Nephrology: Cook County Hospital, Chicago

- Collected urine samples of diabetic and non-diabetic patients and analyzed amount of proteinuria using a new non-immunologic immunofluorescent dye.
- Compared this technique with assessment of total urinary protein using radioimmunoassay.

Literature review on mechanisms of spore germination of *Bacillus subtilis*

1993

Mentor: Dr. H. Y. Cheung

Department of Biology and Chemistry, City University of Hong Kong

- Assisted in preparation of review article discussing recent world literature on mechanisms of protein recognition of DNA.

Immunohistochemical analysis of osteosarcoma

1992

Mentor: Dr. J. C. Lee

Department of Anatomical and Cellular Pathology, Prince of Wales Hospital, Hong Kong:

- Prepared pathologic slides of low grade osteosarcoma specimens and analyzed histology using immunohistochemistry.
-

Professional Activities

Reviewer 2004
American Journal of Nephrology

Service

Pilsen Homeless Shelter, Chicago, IL 1995-1996
Franciscan Homeless Shelter, Chicago, IL 1996-1997
Volunteer Illini Projects, Champaign, IL 1992-1994
Director of Blood Program

Employment History

Nephrologist, J.R. Nephrology & Associates, S.C. June 1, 2005 - Present
Telemarketer, Ameritech, Champaign, IL 1994
Laboratory Assistant 1992-1993
Department of Plant Biology, University of Illinois at Urbana-Champaign

Attending Experience

Advocate Christ Hospital and Medical Center May 26, 2005 - Present
Little Company of Mary Hospital June 9, 2005 - Present
Holy Cross Hospital September 29, 2005 - June 30, 2008

Professional Societies

American Society of Nephrology; Member
National Kidney Foundation; Member, Volunteer
Renal Physicians Association; Member
American College of Physicians; Member
American Medical Association; Member

Personal Information

Date of Birth: July 28, 1973
Place of Birth: Hyderabad, India
Citizenship: U.S.A.

References

Malgorzata Gajda, M.D.
Lawn Medical Center, S.C.
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Oak Lawn, IL 60453
Phone: 708/425-5500
Fax: 708/425-0771

Beata Styka, M.D.
12050 S. Harlem Avenue
Palos Heights, IL 60463
Phone: 708/671-1500
Fax: 708/671-1535

Robert Chalupczak, M.D.
Lawn Medical Center, S.C.
4301 West 95th Street
Oak Lawn, IL 60453
Phone: 708/425-5500
Fax: 708/425-0771

Reference letters available on request.

PROGRAM DESCRIPTION

Introduction to Program

The Hemodialysis Education and Training Program is grounded in DaVita's Core Values. These core values include a commitment to providing *service excellence*, promoting *integrity*, practicing a *team* approach, systematically striving for *continuous improvement*, practicing *accountability*, and experiencing *fulfillment* and *fun*.

The Hemodialysis Education and Training Program is designed to provide the new teammate with the necessary theoretical background and clinical skills necessary to function as a competent hemodialysis patient care provider.

DaVita hires both non-experienced and experienced teammates.

A **non-experienced teammate** is defined as:

- A newly hired patient care teammate without prior dialysis experience.
- A rehired patient care teammate who left prior to completing the initial training.

An **experienced teammate** is defined as:

- A newly hired patient care teammate with prior dialysis experience as evidenced by successful completion of a competency exam.
- A rehired patient care teammate who left and can show proof of completing their initial training.

The curriculum of the Hemodialysis Education and Training Program is modeled after the American Nephrology Nurses Association Core Curriculum for Nephrology Nursing and the Board of Nephrology Examiners Nursing and Technology guidelines.

The program incorporates the policies, procedures, and guidelines of DaVita Inc.

The new teammate will be provided with a "StarTracker". The "StarTracker" is a tool that will help guide the training process while tracking progress. The facility administrator and preceptor will review the Star Tracker to plan and organize the training and professional development of the new teammate. The Star Tracker will guide the new teammate through the initial phase of training and then through the remainder of their first year with DaVita, thus increasing their knowledge of all aspects of dialysis. It is designed to be used in conjunction with the "My Learning Plan Workbooks."

Program Description

- The education program for the newly hired patient care provider teammate **without prior dialysis experience** is composed of at least (1) 120 hours didactic instruction and (2) 280 hours clinical practicum, unless otherwise specified by individual state regulations.

The **didactic phase** consists of instruction including but not limited to lectures, readings, self-study materials, on-line learning activities, specifically designed hemodialysis

workbooks for the teammate, demonstrations and observations. This education may be coordinated by the Clinical Services Specialist (CSS), the administrator, or the preceptor. This training includes introduction to the dialysis machine, components of the hemodialysis system, dialysis delivery system, principles of hemodialysis, infection control, anticoagulation, medications, patient assessment/data collection, vascular access, kidney failure, documentation, complications of dialysis, laboratory draws, and miscellaneous testing devices used, introduction to DaVita Policies and Procedures, and introduction to the Amgen Core Curriculum.

The **didactic phase** also includes classroom training with the Clinical Services Specialist, which covers more in-depth theory on structure and functions of the kidneys. This includes ARF/CRF, uremia, osteodystrophy and anemia, principles of dialysis, components of the hemodialysis system, water treatment, dialyzer reprocessing, hemodialysis treatment (which includes machine troubleshooting and patient complications), documentation, complication case studies, heparinization and anticoagulation, vascular access (which includes vascular access workshop), patient assessment (including workshop), fluid management with calculation workshop, nutrition, laboratory, adequacy, pharmacology, patient teaching/adult learning, service excellence (which includes professionalism, ethics and communications), role of the Social Worker and conflict resolution. Additional topics are included as per specific state regulations.

A final comprehensive examination score of $\geq 80\%$ (unless state requires a higher score) must be obtained to successfully complete this portion of the didactic phase. If a score of less than 80% is attained, the teammate will receive additional appropriate remediation and a second exam will be given.

Also included in the **didactic phase** is additional classroom training covering Health and Safety Training, Systems/applications training on LMS, One For All orientation training in the facility or classroom, LMS Compliance training, LMS Diversity training, LMS mandatory water classes, emergency procedures specific to facility, location of disaster supplies, and orientation to the unit.

Included in the **didactic phase** for nurses is additional classroom training. The didactic phase includes:

- The role of the dialysis nurse
- Critical thinking
- Hepatitis review
- Vascular access assessment
- Pharmacology for nurses
- Outcomes management
- CKD MBD
- Anemia
- Adequacy of dialysis

- Lab results
- Village initiatives
- Fluid management
- Developing plan of care
- Survey readiness
- Patient assessment

The **clinical practicum phase** consists of supervised clinical instruction provided by the facility preceptor, a registered nurse, or the clinical services specialist (CSS). During this phase the teammate will demonstrate a progression of skills required to perform the hemodialysis procedures in a safe and effective manner. A *Procedural Skills Inventory Checklist* will be completed to the satisfaction of the preceptor and the administrator. The clinical hemodialysis workbooks will also be utilized for this training and must be completed to the satisfaction of the preceptor and the administrator.

Those teammates who will be responsible for the Water Treatment System within the facility are required to complete the Mandatory LMS Educational Water courses and the corresponding skills checklists.

Both the didactic phase and/or the clinical practicum phase will be successfully completed prior to the new teammate receiving an independent assignment. The new teammate is expected to attend all training sessions and complete all assignments and workbooks.

- The education program for the newly hired patient care provider teammate **with previous dialysis experience** is individually tailored based on the identified learning needs. The initial orientation to the *Health Prevention and Safety Training* will be successfully completed prior to the new teammate working/receiving training in the clinical area. The *Procedural Skills Inventory Checklist* including verification of review of applicable policies and procedures will be completed by the preceptor, a registered nurse, and/or the clinical services specialist (CSS) and the new teammate upon demonstration of an acceptable skill-level. The new teammate will also utilize the hemodialysis training workbook and progress at their own pace. This workbook should be completed within a timely manner as to also demonstrate acceptable skill-level.

The *Initial Competency Exam* will be completed; a score of $\geq 80\%$ or higher is required prior to the new teammate receiving an independent patient-care assignment. If the new teammate receives a score of less than 80%, this teammate will receive theory instruction pertaining to the area of deficiency and a second competency exam will then be given. If the new teammate receives a score of less than 80% on the second exam, this teammate will be evaluated by the administrator, preceptor, and educator to determine if completion of formal training is appropriate.

Following completion of the training, a *Verification of Competency* form will be completed (see forms TR1-06-05, TR1-06-06). In addition to the above, further training and/or certification will be incorporated as applicable by state law.

Property of DaVita Inc.

Origination Date: 1995

Revision Date: Dec 2007, Sept 2011

Confidential and Copyrighted ©2011

Page 3 of 29

TR1-01-02

The goal of the program is for the trainee to successfully meet all training requirements. Failure to meet this goal is cause for dismissal from the training program and subsequent termination by the facility.

Process of Program Evaluation

The Hemodialysis Education Program utilizes various evaluation tools to verify program effectiveness and completeness. Key evaluation tools include the, DaVita Prep Class Evaluation (TR1-06-08), the New Teammate Satisfaction Survey on the LMS and random surveys of facility administrators to determine satisfaction of the training program. To assure continuous improvement within the education program, evaluation data is reviewed for trends, and program content is enhanced when applicable to meet specific needs.

Program Content

The programs content for the new patient care provider teammate without previous dialysis experience incorporates content related to the following areas.

I. DaVita 101/DaVita Way

A. Behavioral objectives

1. State our mission
3. Describe our six core values
4. Describe the DaVita Way
5. List the team members in their local village

B. Content outline

1. DaVita Village and additional services
2. Our mission
3. Our core values
 - a. Service excellence
 - b. Integrity
 - c. Team
 - d. Continuous improvement
 - e. Accountability
 - f. Fulfillment
 - g. Fun
4. DaVita Way of Communication
 - a. Our language
 - b. VillageWeb
 - c. DaVita Village Voice
 - d. Computer systems
5. Teammate resources
6. One For All
 - a. Process review

II. Treatment Modalities

A. Behavioral objectives

1. Name four treatment options for patients with renal failure

Section VII, Service Specific Review Criteria
In-Center Hemodialysis
Criterion 1110.1430(f), Support Services

Attached at Attachment – 26F is a letter from Arturo Sida, Assistant Corporate Secretary of DaVita HealthCare Partners Inc. and Cagles Dialysis, LLC attesting that the proposed facility will participate in a dialysis electronic data system, will make support services available to patients, and will provide training for self-care dialysis, self-care instruction, home and home-assisted dialysis, and home training.

Kathryn Olson
Chair
Illinois Health Facilities and Services Review Board
525 West Jefferson Street, 2nd Floor
Springfield, Illinois 62761

Re: Certification of Support Services

Dear Chair Olson:

I hereby certify under penalty of perjury as provided in § 1-109 of the Illinois Code of Civil Procedure, 735 ILCS 5/1-109 and pursuant to 77 Ill. Admin. Code § 1110.1430(f) that Chicago Ridge Dialysis will maintain an open medical staff.

I also certify the following with regard to needed support services:

- DaVita utilizes an dialysis electronic data system;
- Chicago Ridge Dialysis will have available all needed support services required by CMS which may consist of clinical laboratory services, blood bank, nutrition, rehabilitation, psychiatric services, and social services; and
- Patients, either directly or through other area DaVita facilities, will have access to training for self-care dialysis, self-care instruction, and home hemodialysis and peritoneal dialysis.

Sincerely,


Print Name: Arturo Sida

Its: Assistant Corporate Secretary
DaVita HealthCare Partners Inc.

Subscribed and sworn to me

This ____ day of _____, 2014

See Attached

Notary Public

State of California

County of Los AngelesOn April 3, 2014 before me, Kimberly Ann K. Burgo, Notary Public
(here insert name and title of the officer)personally appeared Arturo Sida

who proved to me on the basis of satisfactory evidence to be the person(s) whose name(s) is/are subscribed to the within instrument and acknowledged to me that he/she/they executed the same in his/her/their authorized capacity(ies), and that by his/her/their signature(s) on the instrument the person(s), or the entity upon behalf of which the person(s) acted, executed the instrument.

I certify under PENALTY OF PERJURY under the laws of the State of California that the foregoing paragraph is true and correct.

WITNESS my hand and official seal.

Signature

Kimberly Ann K. Burgo

(Seal)

OPTIONAL INFORMATION

Law does not require the information below. This information could be of great value to any person(s) relying on this document and could prevent fraudulent and/or the reattachment of this document to an unauthorized document(s)

DESCRIPTION OF ATTACHED DOCUMENTTitle or Type of Document: Secretary's Certificate - Ltr to K. Olson re Certification of Support ServicesDocument Date: April 3, 2014 Number of Pages: one (1)Signer(s) if Different Than Above: No

Other Information: _____

CAPACITY(IES) CLAIMED BY SIGNER(S)Signer's Name(s): Arturo Sida☐ Individual☒ Corporate Officer

(Title(s))

☐ Partner☐ Attorney-in-Fact☐ Trustee☐ Guardian/Conservator☒ Other: Assistant Corporate Secretary**SIGNER IS REPRESENTING:**Name of Person(s) or Entity(ies): DaVita HealthCare Partners Inc. / Chicago Ridge Dialysis

Section VII, Service Specific Review Criteria

In-Center Hemodialysis

Criterion 1110.1430(g), Minimum Number of Stations

The proposed dialysis facility will be located in the Chicago-Joliet-Naperville metropolitan statistical area ("MSA"). A dialysis facility located within an MSA must have a minimum of eight dialysis stations. The Applicants propose to establish a 16-station dialysis facility. Accordingly, this criterion is met.

Section VII, Service Specific Review Criteria
In-Center Hemodialysis
Criterion 1110.1430(h), Continuity of Care

DaVita HealthCare Partners Inc. has an agreement with Advocate Health and Hospitals Corporation d/b/a Advocate Christ Medical Center to provide inpatient care and other hospital services. Attached at Attachment – 26G is a copy of the service agreement with this area hospital.

**TRANSFER AGREEMENT
BETWEEN
ADVOCATE HEALTH AND HOSPITALS CORPORATION
d/b/a ADVOCATE CHRIST MEDICAL CENTER
AND
STONY CREEK DIALYSIS CENTER**

This Agreement is made and effective as of the 19th day of June, 2006, between Advocate Health and Hospitals Corporation d/b/a Advocate Christ Medical Center, an Illinois not-for-profit corporation ("MEDICAL CENTER"), and Stony Creek Dialysis Center, DaVita, Inc., a for-profit corporation ("FACILITY").

WHEREAS, both parties to this agreement desire to assure continuity of care and treatment appropriate to the needs of each patient in the MEDICAL CENTER and the FACILITY, and to use the skills, resources, and physical plant for patient care at both the acute and post-acute stages of illness.

NOW, THEREFORE, IN CONSIDERATION of the mutual advantage occurring to the parties hereto, the MEDICAL CENTER and FACILITY hereby covenant and agree with each other as follows:

1. Autonomy. The Board of Directors of the MEDICAL CENTER and the Board of Directors of the FACILITY shall continue to have exclusive control of the management, assets and affairs of their institutions, and neither party by virtue of this Agreement shall assume any liability for any debts or obligations which have been or which may be incurred by the other party to this Agreement.
2. Transfer of Patients. Whenever the attending physician of any patient confined in the MEDICAL CENTER or in the FACILITY shall determine that a transfer of such patient from one of these institutions to the other is medically appropriate, the parties shall take whatever steps may be necessary to effect such a transfer in their admissions policies to patients requiring such transfer, subject to availability of bed space, and provided that all the usual conditions for admission are met. Each party shall give notice to the other party, as far in advance as possible, of responsibility of the institution and attending physician initiating transfer to arrange for appropriate and safe transportation. Further, it shall be their responsibility for arranging for the care of the patient during transfer. These responsibilities will cease when the patient has been physically admitted at the designation designated.
3. Medical Center Admissions Priority. In establishing its preference in admission policies for patients subject to transfer from the FACILITY in accordance with Article II, the MEDICAL CENTER shall be guided by its usual admission requirements.

In accordance with criteria for admission:

- A. Patients declared as emergencies by their attending physicians shall be admitted to the MEDICAL CENTER without delay, unless the MEDICAL CENTER is on emergency bypass and has notified applicable agencies of such.
- B. Patients not strictly emergent, but requiring early admission to the MEDICAL CENTER shall be placed on the MEDICAL CENTER's urgent list.
- C. Elective cases shall be booked for future admission to the MEDICAL CENTER, according to the established routine of the MEDICAL CENTER.

4. Facility Admissions Priority. In establishing its preference in admission policies for patients subject to transfer from the MEDICAL CENTER in accordance with Article II, the FACILITY shall be guided by the following plan:

- A. To admit the patient from the MEDICAL CENTER as promptly as possible, provided general admission requirements established by the institution are met.
- B. To give priority to re-admission of patients transferred from the FACILITY to the MEDICAL CENTER.
- C. To accommodate weekend admissions, provided general admission requirements of the FACILITY are met

5. Interchange of Information. The parties shall interchange all pertinent medical records and other information which may be necessary or useful in the care and treatment of patients transferred between the parties or which may be relevant to determining whether such parties can be adequately cared for otherwise than in either the MEDICAL CENTER or FACILITY. All such information shall be provided by the transferring institution in advance, where possible, and in any event at the time of the transfer, and shall be recorded on a referral form which shall be mutually agreed upon by the parties.

6. Transfer of Personal Effects. Procedures for effecting the transfer of patients and their personal effects and valuables shall be developed and adhered to by both parties. These procedures will include, but are not limited to, the provision of information concerning such valuables, money, and personal effects transferred with the patient so that a receipt may be given and received for same. The patient's personal effects will ordinarily be transferred with the patient. The transferring institution will assume responsibility for those personal effects transferred with the patient.

7. Final Financial Arrangements. Charges for services performed by either party for patients transferred from the other party pursuant to this Agreement shall be collected by the party rendering such services directly from the patient, third party payors or from other sources normally billed. Neither party shall have any liability to the other for such charges, except to the extent that such liability would exist separate and apart from the Agreement. Nor shall either party receiving a transferred patient be responsible for collecting any previously outstanding account receivable due the other party from such patient.

8. Insurance. Each party shall maintain professional and public liability insurance coverage in the amount of One Million Dollars (\$1,000,000.000) per occurrence or claim made with respect to the actions of its employees and agents connected with or arising out of services provided under this Agreement.

9. Independent Contractor. Nothing contained in this Agreement shall constitute or be construed to create a partnership, joint venture, employment, or agency relationship between the parties and/or their respective successors and assigns, it being mutually understood and agreed that the parties shall provide the services and fulfill the obligations hereunder as independent contractors. Further, it is mutually understood and agreed that nothing in this Agreement shall in any way affect the independent operation of either the MEDICAL CENTER or the FACILITY. The governing body of the MEDICAL CENTER and the FACILITY shall have exclusive control of the management, assets, and affairs at their respective institutions. No party by virtue of this Agreement shall assume any liability for any debts or obligations of a financial or legal nature incurred by the other, and neither institution shall look to the other to pay for service rendered to a patient transferred by virtue of this Agreement.

10. Nondiscrimination. The parties agree to comply with Title VI of the Civil Rights Act of 1964, all requirements imposed by regulations issued pursuant to that title, section 504 of the Rehabilitation Act of 1973, and all related regulations, to insure that neither party shall discriminate against any recipient of services hereunder on the basis of race, color, sex, creed, national origin, age or handicap, under any program or activity receiving Federal financial assistance.

11. Term and Termination. This Agreement shall commence on **June 19, 2006**, and shall automatically be renewed annually for one year periods unless terminated according to this Section 10. This Agreement may be terminated by either party at any time upon the giving of at least sixty (60) day's prior written notice. Notwithstanding any notice which may have been given, however, this Agreement shall be automatically terminated whenever either party shall have its license to operate revoked, suspended or non-renewed.

12. Notices. All notices required to be served under this Agreement may be served on any of the parties hereto personally or may be served by sending a letter duly addressed by registered or certified mail. Notices to be served on the MEDICAL CENTER shall be served at or mailed to: Advocate Christ Medical Center, attention President, at 4440 West 95th Street, Oak Lawn, Illinois 60453 with a copy to Chief Legal Officer, Advocate Health and Hospitals Corporation at 2025 Windsor Drive, Oak Brook, Illinois 60521. Notices to be served on FACILITY shall be

served at or mailed to: Stony Creek Dialysis Center, attention Facility Administrator, at 9115 South Cicero Avenue, Oak Lawn, Illinois 60453, unless otherwise instructed.

13. Advertising and Publicity. Neither party shall use the name of the other party in any promotional or advertising material unless review and approval of those intended use shall be first be obtained from the party whose name is to be used.

14. Nonexclusive Clause. Nothing in this Agreement shall be construed as limiting the right of either party to affiliate or contract with any other MEDICAL CENTER or FACILITY, or either a limited or general basis, while this Agreement is in effect.

15. Amendment. This Agreement may be amended, modified, or supplemented by agreement of both parties, but no such modification, amendment, or supplement shall be binding on either party unless and until the same is attached hereto in writing and signed by authorized officials of both parties.

16. Governing Law. All questions concerning the validity or construction of this Agreement shall be determined in accordance with the laws of Illinois.

||| IN WITNESS WHEREOF, this Agreement has been executed by the MEDICAL CENTER and the FACILITY on the date first written above.

ADVOCATE HEALTH AND HOSPITALS CORPORATION
d/b/a ADVOCATE CHRIST MEDICAL CENTER

By: Kenneth W. Shepherd
President

STONY CREEK DIALYSIS CENTER, DAVITA, INC.

By: MBalas
Facility Administrator

28943

Section VII, Service Specific Review Criteria
In-Center Hemodialysis
Criterion 1110.1430(i), Relocation of Facilities

The Applicants propose the establishment of a 16-station dialysis facility. Thus, this criterion does is not applicable.

Section VII, Service Specific Review Criteria
In-Center Hemodialysis
Criterion 1110.1430(j), Assurances

Attached at Attachment – 26H is a letter from Arturo Sida, Assistant Corporate Secretary, DaVita HealthCare Partners Inc. certifying that the proposed facility will achieve target utilization by the second year of operation

Kathryn Olson
Chair
Illinois Health Facilities and Services Review Board
525 West Jefferson Street, 2nd Floor
Springfield, Illinois 62761

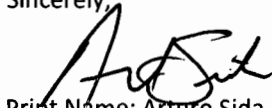
Re: In-Center Hemodialysis Assurances

Dear Chair Olson:

Pursuant to 77 Ill. Admin. Code § 1110.1430(j), I hereby certify the following:

- By the second year after project completion, Chicago Ridge Dialysis expects to achieve and maintain 80% target utilization; and
- Chicago Ridge Dialysis also expects hemodialysis outcome measures will be achieved and maintained at the following minimums:
 - $\geq 85\%$ of hemodialysis patient population achieves urea reduction ratio (URR) $\geq 65\%$ and
 - $\geq 85\%$ of hemodialysis patient population achieves Kt/V Daugirdas II .1.2

Sincerely,



Print Name: Arturo Sida

Its: Assistant Corporate Secretary
DaVita HealthCare Partners Inc.

Subscribed and sworn to me

This ____ day of _____, 2014



Notary Public

State of California

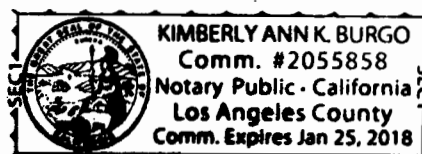
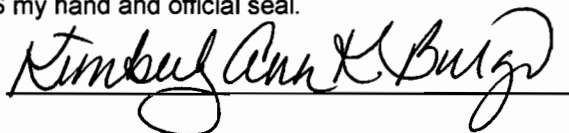
County of Los AngelesOn April 3, 2014 before me, Kimberly Ann K. Burgo, Notary Public
(here insert name and title of the officer)personally appeared Arturo Sida

who proved to me on the basis of satisfactory evidence to be the person(s) whose name(s) is/are subscribed to the within instrument and acknowledged to me that he/she/they executed the same in his/her/their authorized capacity(ies), and that by his/her/their signature(s) on the instrument the person(s), or the entity upon behalf of which the person(s) acted, executed the instrument.

I certify under PENALTY OF PERJURY under the laws of the State of California that the foregoing paragraph is true and correct.

WITNESS my hand and official seal.

Signature



(Seal)

OPTIONAL INFORMATION

Law does not require the information below. This information could be of great value to any person(s) relying on this document and could prevent fraudulent and/or the reattachment of this document to an unauthorized document(s)

DESCRIPTION OF ATTACHED DOCUMENTTitle or Type of Document: Secretary's Certificate - Ltr to K. Olson re In-Center Hemodialysis AssurancesDocument Date: April 3, 2014 Number of Pages: one (1)Signer(s) if Different Than Above: No

Other Information: _____

CAPACITY(IES) CLAIMED BY SIGNER(S)Signer's Name(s): Arturo Sida☐ Individual☒ Corporate Officer

(Title(s))

☐ Partner☐ Attorney-in-Fact☐ Trustee☐ Guardian/Conservator☒ Other: Assistant Corporate Secretary**SIGNER IS REPRESENTING:**Name of Person(s) or Entity(ies): DaVita HealthCare Partners Inc. / Chicago Ridge Dialysis

Section VIII, Financial Feasibility
Criterion 1120.120 Availability of Funds

The project will be funded entirely with cash and cash equivalents, and a lease from Palestra Real Estate Partners, Inc. A copy of DaVita's 2013 10-K Statement evidencing sufficient internal resources to fund the project was previously submitted with the application for Project No. 14-016. A letter of intent to lease the facility is attached at Attachment – 36A.



May 1, 2014

Mr. Edgar Levin
USI REAL ESTATE BROKERAGE SERVICES INC.
2215 YORK RD, SUITE 110
OAKBROOK, IL 60523

RE: RESPONSE v8 to Request for Proposal – former Aldi Store Redevelopment
10511 South Harlem Avenue, Worth, IL

Dear Edgar:

Thank you for the Request for Proposal. Below please find our written response to lease the above-referenced Property to be redeveloped by Palestra Real Estate Partners, Inc. or its assigns through the DaVita Preferred Developer Program ("PDP").

DISCLOSURE:

USI Real Estate Brokerage Services Inc. discloses that this Request for Proposal is subject to the terms of Exhibit A attached hereto. The information in this email is confidential and may be legally privileged. It is intended solely for the addressee. Access to this email by anyone else is unauthorized.

PREMISES:

10511 South Harlem Avenue, Worth, IL

LEGAL DESCRIPTION:

See Exhibit C

TENANT (or "Lessee"):

Total Renal Care, Inc. or related entity to be named

LANDLORD (or "Lessor"):

Palestra Real Estate Partners, Inc. or its assigns

SPACE:

Approximately 7,423 contiguous rentable square feet.

PRIMARY TERM & BASE RENT:

Proposed Term and Base Rent is summarized here, and shall be per the Tenant PDP Lease form and the attached Prelim Budget.

Years 1- 5: \$172,065.14 per annum (~\$23.18/Rsf)

Years 6-10: \$189,286.50 per annum (~\$25.50/Rsf)

Years 11-15: \$208,215.15 per annum (~\$28.05/Rsf)

ADDITIONAL EXPENSES:

Tenant shall pay additional expenses and additional rent according to the Tenant PDP Lease form. Tenant's pro rata share percentage of the Building shall be 72.14%, which equals 9,638 (total Tenant space) divided by the Building total square feet of 13,360.

LANDLORD'S MAINTENANCE:

Landlord shall be responsible as called for by the Tenant PDP Lease form.

POSSESSION AND

RENT COMMENCEMENT:

Landlord shall deliver Possession of the Premises to the Tenant as called for by the Tenant PDP Lease form. Rent Commencement shall be as called for by the Tenant PDP Lease form.

USE:

The Tenant's Use is as called for by the Tenant PDP Lease form. The Tenant's Architect will verify that the Property's Zoning will allow the Tenant's dialysis use. The Tenant's Provisioning Team will determine the postal address it wants.

PARKING:

Preliminarily, from the Site Plan provided by the Seller, it appears the Property contains 87 total parking stalls (a Property ratio of 6.5 per 1000 Rsf). Tenant may have its pro rata share of the Property's parking stalls. Assuming 72.14% and 87, then Tenant may have the unreserved use of 63 parking stalls 6.5 per 1000 Rsf).

BASE BUILDING:

Landlord shall deliver to the Base Building as called for by the Tenant PDP Lease form and by the attached Exhibit B.

TENANT ALLOWANCE:

None.

OPTION TO RENEW:

As called for by the Tenant PDP Lease form.

**RIGHT OF FIRST OPPORTUNITY
ON ADJACENT SPACE:**

Tenant shall have a one-time right of first opportunity, on the adjacent 3,722 Rsf space, such right expiring 12/31/2014. If Tenant leases this space, it shall be under the same terms and conditions of the Tenant PDP Lease form – and made coterminous and thus prorating any other items as necessary to make both Landlord and Tenant whole.

**FAILURE TO DELIVER
PREMISES:**

As called for by the Tenant PDP Lease form.

HOLDING OVER:

As called for by the Tenant PDP Lease form.

TENANT SIGNAGE:

As called for by the Tenant PDP Lease form.

BUILDING HOURS:

As called for by the Tenant PDP Lease form.

SUBLEASE/ASSIGNMENT:

As called for by the Tenant PDP Lease form.

ROOF RIGHTS:

As called for by the Tenant PDP Lease form.

NON COMPETE:

As called for by the Tenant PDP Lease form.

HVAC:

As called for by the Tenant PDP Lease form and attached Exhibit B.

DELIVERIES:

As called for by the Tenant PDP Lease form.

OTHER CONCESSIONS:

As called for by the Tenant PDP Lease form.

**GOVERNMENTAL
COMPLIANCE:**

As called for by the Tenant PDP Lease form.

CONTINGENCIES:

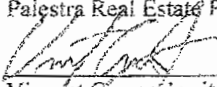
Tenant CON Obligation: Landlord and Tenant understand and agree that the establishment of any chronic outpatient dialysis facility in the State of Illinois is subject to the requirements of the Illinois Health Facilities Planning Act, 20 ILCS 3960/1 et seq. and, thus, the Tenant cannot establish a dialysis facility on the Premises or execute a binding real estate lease in connection therewith unless Tenant obtains a Certificate of Need (CON) permit from the Illinois Health Facilities and Services Review Board (HFSRB). Based on the length of the HFSRB review process, Tenant does not expect to receive a CON permit prior to August 1, 2014. In light of the foregoing facts, the parties agree that they shall promptly proceed with due diligence to negotiate the terms of a definitive lease agreement and execute such agreement prior to approval of the CON permit *provided, however, the lease shall not be binding on either party prior to approval of the CON permit and the lease agreement shall contain a contingency clause indicating that the lease agreement is not effective prior to CON permit approval.* Assuming CON approval is granted, the effective date of the lease agreement shall be the first day of the calendar month following CON permit approval. In the event that the HFSRB does not award Tenant a CON permit to establish a dialysis center on the Premises by August 1, 2014 neither party shall have any further obligation to the other party with regard to the negotiations, lease, or Premises contemplated by this Letter of Intent.

BROKERAGE FEE:

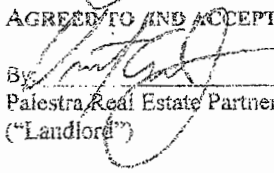
Landlord recognizes USI Real Estate Brokerage Services Inc. as the Tenant's sole representative and shall pay a brokerage fee, per the Tenant PDP, per separate commission agreement.

Thank you for the opportunity to respond to the Request for Proposal.

Sincerely,
Palestra Real Estate Partners, Inc.


Vincent Curran Jr., its President

AGREED TO AND ACCEPTED THIS 12th DAY OF MAY 2014

By: 
Palestra Real Estate Partners, Inc.
("Landlord")

AGREED TO AND ACCEPTED THIS 13th DAY OF MAY 2014

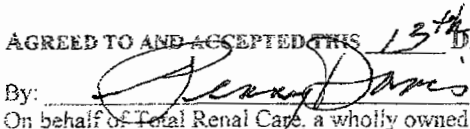
By: 
On behalf of Total Renal Care, a wholly owned subsidiary of
DaVita HealthCare Partners, Inc.
("Tenant")

EXHIBIT A

NON-BINDING NOTICE

NOTICE: THE PROVISIONS CONTAINED IN THIS LETTER OF INTENT ARE AN EXPRESSION OF THE PARTIES' INTEREST ONLY. SAID PROVISIONS TAKEN TOGETHER OR SEPARATELY ARE NEITHER AN OFFER WHICH BY AN "ACCEPTANCE" CAN BECOME A CONTRACT, NOR A CONTRACT. BY ISSUING THIS LETTER OF INTENT NEITHER TENANT NOR LANDLORD (OR USI) SHALL BE BOUND TO ENTER INTO ANY (GOOD FAITH OR OTHERWISE) NEGOTIATIONS OF ANY KIND WHATSOEVER. TENANT RESERVES THE RIGHT TO NEGOTIATE WITH OTHER PARTIES. NEITHER TENANT, LANDLORD OR USI INTENDS ON THE PROVISIONS CONTAINED IN THIS LETTER OF INTENT TO BE BINDING IN ANY MANNER, AS THE ANALYSIS FOR AN ACCEPTABLE TRANSACTION WILL INVOLVE ADDITIONAL MATTERS NOT ADDRESSED IN THIS LETTER, INCLUDING, WITHOUT LIMITATION, THE TERMS OF ANY COMPETING PROJECTS, OVERALL ECONOMIC AND LIABILITY PROVISIONS CONTAINED IN ANY LEASE DOCUMENT AND INTERNAL APPROVAL PROCESSES AND PROCEDURES. THE PARTIES UNDERSTAND AND AGREE THAT A CONTRACT WITH RESPECT TO THE PROVISIONS IN THIS LETTER OF INTENT WILL NOT EXIST UNLESS AND UNTIL THE PARTIES HAVE EXECUTED A FORMAL, WRITTEN LEASE AGREEMENT APPROVED IN WRITING BY THEIR RESPECTIVE COUNSEL. USI IS ACTING SOLELY IN THE CAPACITY OF SOLICITING, PROVIDING AND RECEIVING INFORMATION AND PROPOSALS AND NEGOTIATING THE SAME ON BEHALF OF OUR CLIENTS. UNDER NO CIRCUMSTANCES WHATSOEVER DOES USI HAVE ANY AUTHORITY TO BIND OUR CLIENTS TO ANY ITEM, TERM OR COMBINATION OF TERMS CONTAINED HEREIN. THIS LETTER OF INTENT IS SUBMITTED SUBJECT TO ERRORS, OMISSIONS, CHANGE OF PRICE, RENTAL OR OTHER TERMS; ANY SPECIAL CONDITIONS IMPOSED BY OUR CLIENTS; AND WITHDRAWAL WITHOUT NOTICE. WE RESERVE THE RIGHT TO CONTINUE SIMULTANEOUS NEGOTIATIONS WITH OTHER PARTIES ON BEHALF OF OUR CLIENT. NO PARTY SHALL HAVE ANY LEGAL RIGHTS OR OBLIGATIONS WITH RESPECT TO ANY OTHER PARTY, AND NO PARTY SHOULD TAKE ANY ACTION OR FAIL TO TAKE ANY ACTION IN DETRIMENTAL RELIANCE ON THIS OR ANY OTHER DOCUMENT OR COMMUNICATION UNTIL AND UNLESS A DEFINITIVE WRITTEN LEASE AGREEMENT IS PREPARED AND SIGNED BY TENANT AND LANDLORD.



Exhibit B

MINIMUM BASE BUILDING IMPROVEMENT REQUIREMENTS

[SUBJECT TO MODIFICATION BASED ON INPUT FROM LESSEE'S PROJECT MANAGER WITH RESPECT TO EACH CENTER PROJECT]

At a minimum, the Lessor shall provide the following Base Building Improvements to meet Lessee's requirements for an Existing Base Building Improvements at Lessor's sole cost:

All MBBI work completed by the Lessor will need to be coordinated and approved by the Lessee and there Consultants prior to any work being completed, including shop drawings and submittals reviews.

1.0 - Building Codes & Design

All Minimum Base Building Improvements (MBBI) are to be performed in accordance with all local, state, and federal building codes including any related amendments, fire and life safety codes, ADA regulations, State Department of Public Health, and other applicable and codes as it pertains to Dialysis. All Lessor's work will have Governmental Authorities Having Jurisdiction ("GAHJ") approved architectural and engineering (Mechanical, Plumbing, Electrical, Structural, Civil, Environmental) plans and specifications prepared by a licensed architect and engineer.

Lessee shall have full control over the selection of the General Contractor for the tenant improvement work.

2.0 - Zoning & Permitting

Building and premises must be zoned to perform services as a dialysis clinic. Lessor to provide all Zoning information related to the base building. Any new Zoning changes/variances necessary for use of the premises as a dialysis clinic shall be the responsibility of the Lessee with the assistance of the Lessor to secure Zoning change/variance. Permitting of the interior construction of the space will be by the Lessee.

3.0 - Common Areas

Lessee will have access and use of all common areas i.e. Lobbies Hallways, Corridors, Restrooms, Stairwells, Utility Rooms, Roof Access, Emergency Access Points and Elevators. All common areas must be code and ADA compliant (Life Safety, ADA, etc.) per current federal, state and local code requirements.

4.0 - Demolition

Lessor will be responsible for demolition of all interior partitions, doors and frames, plumbing, electrical, mechanical systems (other than what is designated for reuse by Lessee) and finishes of the existing building from slab to roof deck to create a "Vanilla box" condition. Space shall be broom clean and ready for interior improvements specific to the buildout of a dialysis facility. Building to be free and clear of any components, asbestos or material that is in violation of any EPA standards of acceptance and local hazardous material jurisdiction standards.

5.0 - Foundation and Floor

Existing Foundations and Slab on Grade in Lessee space must be free of cracks and settlement issues. Any cracks and settlement issues evident at any time prior commencement of tenant improvement work shall be subject to inspection by a Licensed Structural Engineer stating that such cracks and / or settlement issues are within limits of the structural integrity and performance anticipated for this concrete and reinforcement design for the term of the lease. Lessor to confirm that the site does not contain expansive soils and to confirm the depth of the water table. Existing concrete slabs shall contain control joints and structural reinforcement.

All repairs will be done by Lessor at his cost and be done prior to Lessee acceptance of space for construction. Any issues with slab during Lessee construction will be brought up to Lessor attention and cost associated with slab issue to repair will be paid by Lessor.

Any slab replacement will be of the same thickness of the adjacent slab (or a minimum of 5") with a minimum concrete strength of 3,000-psi with wire or fiber mesh, and/or rebar reinforcement over vapor barrier and granular fill. Infill slab/trenches will be pinned to existing slab at 24" O.C. with # 4 bars or greater x 16" long or as designed per higher standards by Lessee's structural engineer depending on soils and existing slab condition.

Existing Concrete floor shall not have more than 3-lbs. of moisture per 1,000sf/24 hours is emitted per completed calcium chloride testing results. Means and methods to achieve this level will be sole responsibility of the Lessor.

6.0 - Structural

Existing exterior walls, lintels, floor and roof framing shall remain as-is and be free of defects. Should any defects be found repairs will be made by Lessor at his cost. Any repairs will meet with current codes and approved by a Structural Engineer and Lessee.

Lessor shall supply Lessee (if available) structural engineering drawings of space

7.0 - Existing Exterior Walls

All exterior walls shall be in good shape and properly maintained. Any damaged drywall and or Insulation will be replaced by Lessor prior to Lessee taking possession.

It will be the Lessor's responsibility for all cost to bring exterior walls up to code before Lessee takes possession.

8.0 - Demising walls

New or Existing demising walls shall be a 1 or 2hr fire rated wall depending on local codes, state and or regulatory requirements (NFPA 101 - 2000) whichever is more stringent. If it does not meet this, Lessor will bring demising wall up to meet the ratings/UL requirements. Walls to be fire caulked in accordance with UL standards at floor and roof deck. Demising walls will have sound attenuation batts from floor to underside of deck.

At Lessee's option and as agreed upon by Lessor, any new demising wall interior drywall to lessee's space shall not be installed until after Lessee's improvements are complete in the wall.

9.0- Roof Covering

The roof shall be properly sloped for drainage and flashed for proper water shed. The roof, roof drains and downspouts shall be properly maintained to guard against roof leaks and can properly drain. Lessor will provide Lessee the information on the Roof and Contractor holding warranty. Lessor to provide minimum

of R30 roof insulation at roof deck. If the R30 value is not meet, Lessor to increase R-Value by having installed additional insulation to meet GAHJ requirements to the underside of the roof structure/deck.

Any new penetrations made during buildout will be at the Lessee's cost. Lessor shall grant Lessee that right to conceal or remove existing skylights as deemed appropriate by Lessee and their Consultants.

10.0 – Canopy

Lessor shall allow Lessee to design and construct a canopy structure for patient drop off and if allowed local code.

11.0 – Waterproofing and Weatherproofing

Lessor shall provide complete water tight building shell inclusive but not limited to, Flashing and/or sealant around windows, doors, parapet walls, Mechanical / Plumbing / Electrical penetrations. Lessor shall properly seal the building's exterior walls, footings, slabs as required in high moisture conditions such as (including but not limited to) finish floor sub-grade, raised planters, and high water table. Lessor shall be responsible for replacing any damaged items and repairing any deficiencies exposed during / after construction of tenant improvement.

12.0 – Windows

Any single pane window systems must be replaced by Lessor with code compliant Energy efficient thermal pane windows with thermally broken aluminum frames. Broken, missing and/or damaged glass or frames will be replaced by Lessor. Lessor shall allow Lessee, at Lessee's discretion, to tint the existing windows (per manufactures recommendations) per Lessee's tenant improvement design.

13.0 – Thermal Insulation

Lessor to replace any missing and/or damaged wall or ceiling insulation with R-13, 19 or R30 insulation. Any new roof deck insulation is to be installed to the underside of the roof deck.

14.0 – Exterior Doors

All exterior doors shall meet American Disabilities Act (ADA), Local Codes and State Department of Health requirements for egress. If not Lessor at his cost will need to bring them up to code, this will include installing push paddles and/or panic hardware or any other hardware for egress. Any missing weather stripping, damage to doors or frames will be repaired or replaced by Lessor.

Lessor will provide, if not already present, a front entrance and rear door to space. Should one not be present at each of the locations Lessor, to have them installed per the following criteria:

- Front/ Patient Entry Doors: Provide Storefront with insulated glass doors and Aluminum framing to be 42" width including push paddle/panic bar hardware, continuous hinge and lock mechanism. Door to be prepped to accept power assist opener and push button keypad lock provided by Lessee.
- Service Doors: Provide 72" wide double door (Alternates for approval by Lessee's Project Manager to include: 60" Roll up door, or a 48" wide single door or double door with 36" and 24" doors) with 20 gauge insulated hollow metal (double doors), Flush bolts, T astragal, Heavy Duty Aluminum threshold, continuous hinge each leaf, prepped for panic bar hardware (as required by code) painted with rust inhibiting paint and prepped to receive a push button keypad lock provided by Lessee. Door to have a 10" square vision panel cut out with insulated glass installed if requested by Lessee.

Any doors that are designated to be provided modified or prepared by Lessor; Lessor shall provide to Lessee, prior to door fabrication, submittals containing specification information, hardware and shop drawings for review and acceptance by Lessee and Lessee's architect.

15.0 – Utilities

All utilities to be provided at designated utility entrance points into the building at locations approved by the Lessee at a common location for access. Lessor is responsible for all tap/connection and impact fees for all new utilities required for a dialysis facility. All Utilities to be coordinated with Lessee's Architect.

16.0 – Plumbing

Lessor to provide a building water service sized to support Lessee's potable water demand, building fire sprinkler water demand (if applicable), and other tenant water demand (if applicable). Final size to be determined by building potable and sprinkler water combined by means of the total building water demand based on code derived water supply fixture unit method and the building fire sprinkler water hydraulic calculations, per applicable codes and in accordance to municipality and regulatory standards. Lessor to provide a minimum potable water supply to support 30 (60) GPM with a constant 50 PSI water pressure, or as determined by Lessee's Engineer based on Lessee's water demand. Maximum water pressure to Lessee space to not exceed 80 PSI, and where it does water supply to be provided with a pressure reducing valve. Lessor to provide Lessee with a current water flow test results (within current year) indicating pressure and flow, for Lessee's approval.

Where suitable building water already exists, Lessor to provide Lessee with a potable water supply to meet the above minimum requirements. Water flow and pressure to Lessee's space to be unaffected by any other building water requirements such as other tenant water requirements or irrigation systems. Lessor to bring water to Lessee's space, leaving off with a valve and cap for Lessee extension per Lessee direction or Lessee design plans.

Potable water supply to be provided with water meter and two (2) reduced pressure zone (RPZ) backflow devices arranged in parallel for uninterrupted service and sized to support required GPM demand. Backflow devices to be provided with adequate drainage per code and local authority. Meter to be per municipality or water provider standards.

Any existing hose bibs will be in proper working condition prior to Lessee's possession of space.

Building sanitary drain size will be determined by Lessee's Mech Engineer based on total combined drainage fixture units (DFU's) for entire building, but not less than 4 inch diameter. The drain shall be stubbed into the building per location coordinated by Lessee at an elevation no higher than 4 feet below finished floor elevation, to a maximum of 10 feet below finished floor elevation. (Coordinate actual depth and location with Lessee's Architect and Engineer.) Provide with a cleanout structure at building entry point. New sanitary building drain shall be properly pitched to accommodate Lessee's sanitary system design per Lessee's plumbing plans, and per applicable Plumbing Code(s). Lift station/sewage ejectors will not be permitted.

Sanitary drain to be stubbed into Lessee's space with a minimum invert level of 42 inches below finished slab. Sanitary drain to be sized based on the calculated drainage fixture unit (DFU) method in accordance to code for both the Lessee's DFU's combined with any other tenant DFU's sharing the drain however, in no case less than 4 inch diameter. Ejectors or lift stations are prohibited. Lessor to clean, power jet and televise existing sanitary drain and provide Lessee with a copy of results. Any drains displaying disrepair or improper pitch shall be corrected by Lessor prior to acceptance by Lessee. Where existing conditions are not met, Lessor to provide new sanitary drain to meet such requirements at Lessor's cost and include all relevant Sanitary District and local municipality permit, tap and other fees for such work.

Lessor to provide a plumbing vent no less than 4 inch diameter stubbed into Lessee's space as high as possible with an elevation no less than the bottom of the lowest structural element of the framing to the deck above. Where deck above is the roof, Lessor to provide roof termination and all required roof flashing and waterproofing. Plumbing roof terminations to maintain a minimum separation of 15 feet, or

more if required by local code, from any mechanical rooftop equipment with fresh air intake. Where required separation does not exist, Lessor to relocate to be within compliance at Lessor's cost.

Sanitary sampling manhole if required by local municipality on new line.

Lessor to provide and pay for all tap fees related to new sanitary sewer and water services in accordance with local building and regulatory agencies.

17.0 - Fire Suppression and Alarm System

Fire Sprinkler Systems and building fire alarm control panel shall be maintained by Lessor. Lessor to provide pertinent information on systems for Lessee Engineers for design. Lessor to provide current vendor for system and monitoring company.

Where Sprinkler System is not present and is required by Lessee usage based on local code or NFPA 101, Lessor to provide cost, to be included in lease rate, for the design and installation of a complete turnkey sprinkler system (less drops and heads in lessee space) that meets all local building, fire prevention and life safety codes for the entire building. This system to be on a dedicated water line independent of Lessee's potable water line requirements. Lessor to include all municipal approved shop drawings, service drops and sprinkler heads at heights per Lessee's reflective ceiling plan, flow control switches wired and tested, alarms including wiring and an electrically/telephonically controlled fire alarm control panel connected to a monitoring systems for emergency dispatch.

18.0 - Electrical

Service size to be determined by Lessee's engineer dependant on facility size and gas availability (400amp to 1,000amp service) 120/208 volt, 3 phase, 4 wire derived from a single metered source and consisting of dedicated CT cabinet per utility company standards feeding a distribution panelboard in the Lessee's utility room (location to be per National Electrical Code (NEC) and coordinated with Lessee and their Architect) for Lessee's exclusive use in powering equipment, appliances, lighting, heating, cooling and miscellaneous use. Lessor's service provisions shall include utility metering, tenant service feeder, and distribution panelboard with main and branch circuit breakers. Lessee will not accept multiple services to obtain the necessary capacity. Should this not be available Lessor to upgrade electrical service to meet the following criteria:

Provide new service (preferably underground) with a dedicated meter via a new CT cabinet per utility company standards. Service size to be determined by Lessee's engineer dependant on facility size and gas availability (**preliminary estimate = 1,000 amp service**) 120/208 volt, 3 phase, 4 wire to a distribution panelboard in the Lessee's utility room (location to be per NEC and coordinated with Lessee and their Architect) for Lessee's exclusive use in powering equipment, appliances, lighting, heating, cooling and miscellaneous use. Lessor's service provisions shall include transformer coordination with utility company, transformer pad and grounding, and underground conduit and wire sized for service inclusive of excavation, trenching and restoration, utility metering, distribution panelboard with main and branch circuit breakers, and electrical service and building grounding per NEC.

Lessee's Engineer shall have the final approval on the electrical service size and location and the size and quantity of circuit breakers to be provided in the distribution panelboard. If 480V power is supplied, Lessor to provide step down transformer to Lessee requirements above.

If combined service meter cannot be provided then Lessor shall provide written verification from Power Utility supplier stating multiple meters are allowed for use by the facility for the duration of the lease term.

If lease space is in a multi-tenant building then Lessor to provide meter center with service disconnecting means, service grounding per NEC, dedicated combination CT cabinet with disconnect for Lessee and distribution panelboard per above.

Lessor will allow Lessee to have installed, at Lessee cost, Transfer Switch for temporary generator hook-up, or permanent generator.

Existing electrical raceway, wire, and cable extending through the Lessee's space but serving areas outside the Lessee's space shall be re-routed outside the Lessee's space and reconnected as required at the Lessor's cost.

Fire Alarm system shall be maintained and in good working order by Lessor prior to Lessee acceptance of space. Lessor to provide pertinent information on systems for Lessee's design. Lessor to provide current vendor for system and monitoring company. Lessor's Fire Alarm panel shall include supervision of fire suppression system(s) and connections to emergency dispatch or third party monitoring service in accordance with the local authority having jurisdiction. If lease space is in a multi-tenant building then Lessor to provide an empty conduit stub in Lessee space from Lessor's Fire Alarm panel. If Fire Alarm system is unable to accommodate Lessee requirements and/or FA system is not within applicable code compliance, Lessor to upgrade panel at Lessor's cost.

Fire Alarm system equipment shall be equipped for double detection activation if required.

19.0 - Gas Service

Existing Natural gas service at a minimum to have a 6" water column pressure and be able to supply 800,000-BTU's. Natural gas line shall be individually metered and sized per demand.

20.0 - Mechanical /Heating Ventilation Air Conditioning

Lessor to provide a detailed report from a HVAC company on all existing HVAC units i.e. age, CFM's, cooling capacity, service records etc for review by Lessee. HVAC Units, components and equipment that Lessee intends to reuse shall be left in place 'as is' by Lessor. Lessor shall allow Lessee, at Lessee's discretion to remove, relocate, replace or modify existing unit(s) as needed to meet HVAC code requirements and design layout requirements.

If determined by Lessee that the units need to be replaced and or additional units are needed, Lessor will be responsible for the cost of the replacement/additional HVAC units, Lessee will complete the all work with the replacement/additional HVAC Units. Units replaced or added will meet the design requirements as stated below.

The criteria is as follows:

- Equipment to be Carrier or Trane RTU's
- Supply air shall be provided to the Premises sufficient for cooling and ventilation at the rate of 275 to 325 square feet per ton to meet Lessee's demands for a dialysis facility and the base building Shell loads.
- Ductwork shall be extended 5' into the space for supply and return air.
- System to be a fully ducted return air design
- All ductwork to be externally lined except for the drops from the units.
- Provide 100% enthalpy economizer
- Units to include Power Exhaust
- Controls to be Programmable or DDC
- Provide high efficiency inverter rated non-overloading motors
- Provide 18" curbs, 36" in Northern areas with significant snow fall
- Units to have disconnect and service outlet
- Units will include motorized dampers dampers for OA, RA & EA

- System shall be capable of providing 55deg supply air temperature when it is in the cooling mode

Equipment will be new and come with a full warranty on all parts including compressors (minimum of 5yrs) including labor. Work to include, but not limited to, the purchase of the units, installation, roof framing, mechanical curbs, flashings, gas & electrical hook-up, thermostats and start-up. Anticipate minimum up to five (5) zones with programmable thermostat and or DDC controls (Note: The 5 zones of conditioning may be provided by individual constant volume RTU's, or by a VAV or VVT system of zone control with a single RTU). Lessee's engineer shall have the final approval on the sizes, tonnages, zoning, location and number of HVAC units based on Lessees' design criteria and local and state codes.

21.0 - Telephone

If in a multi tenant building Lessor to provide a 1" conduit from Building Demark location to phone room location in Lessee space.

22.0 - Cable or Satellite TV

Lessee shall have the right to place a satellite dish on the roof and run appropriate electrical cabling from the Premises to such satellite dish and/or install cable service to the Premises at no additional fee. Lessor shall reasonably cooperate and grant "right of access" with Lessee's satellite or cable provider to ensure there is no delay in acquiring such services.

23.0 - Handicap Accessibility

Full compliance with ADA and all local jurisdictions' handicap requirements. Lessor shall comply with all ADA regulations affecting the Building and entrance to Lessee space including, but not limited to, the elevator, exterior and interior doors, concrete curb cuts, ramps and walk approaches to / from the parking lot, parking lot striping for four (4) dedicated handicap stalls for a unit up to 20 station clinic and six (6) HC stalls for units over 20 stations inclusive of pavement markings and stall signs with current local provisions for handicap parking stalls, delivery areas and walkways.

Lessor shall provide pavement marking; curb ramp and accessible path of travel for a dedicated delivery access in the rear of the building. The delivery access shall link the path from the driveway paving to the designated Lessee delivery door and also link to the accessible path of travel.

24.0 - Generator

Lessor to allow a generator to be installed onsite if required by code or Lessee chooses to provide one.

25.0 - Existing Site Lighting

Lessor to provide adequate lighting per code and to illuminate all parking, pathways, for new and existing building access points. Parking lot lighting to be on a timer (and be programmed per Lessee business hours of operation) or photocell. Parking lot lighting shall be connected to and powered by Lessor house panel and equipped. If new lighting is provided it will need to be code compliant with a 90 minute battery back up at all access points.

26.0 - Exterior Building Lighting

Lessor to provide adequate lighting per code and to illuminate the building main and service entrance/exits with related sidewalks. Lighting shall be connected to and powered by Lessor house panel and equipped with a code compliant 90 minute battery back up at all access points.

27.0 – Parking Lot

Provide adequate amount of ADA curb cuts, handicap and standard parking stalls in accordance with dialysis use and overall building uses. Stalls to receive striping, lot to receive traffic directional arrows and concrete parking bumpers. Bumpers to be anchored in place onto the asphalt per stall layout.

28.0 – Refuse Enclosure

If an area is not designated, lessor to provide Refuse area for Lessee dumpsters. Lessor to provide a minimum 6" thick reinforced concrete pad approx 100 to 150SF based and an 8' x 12' apron way to accommodate dumpster and vehicle weight. Enclosure to be provided as required by local codes.

29.0 - Signage

Lessor to allow for an illuminated façade mounted sign and rights to add signage to existing Pylon/monument sign. Final sign layout to be approved by Lessee and the City.

Exhibit C – Legal Description, Tax & Survey Information

Tax Parcel One:

The west 65.80 feet (measured perpendicular to the west line) of Lot 1 in Aldi subdivision, being a subdivision of part of the northwest $\frac{1}{4}$ of Section 18, Township 37 North, Range 13, east of the Third Principal Meridian, according to the Plat thereof recorded June 18, 1990 as document number 90-287592, in Cook County, Illinois.

Tax Parcel Four:

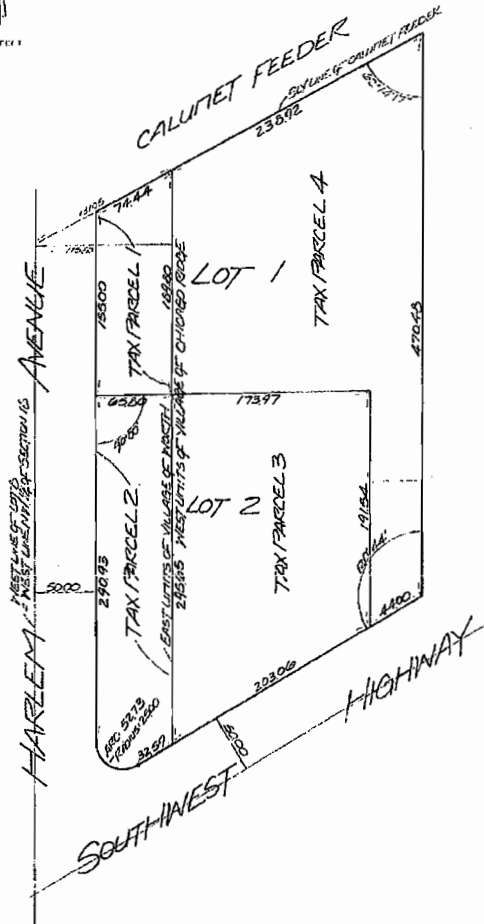
Lot 1 (except the west 65.80 feet measured perpendicular to the west line thereof) in Aldi subdivision being a subdivision of part of the northwest $\frac{1}{4}$ of Section 18, Township 37 North, Range 13, east of the Third Principal Meridian, according to the Plat thereof recorded June 18, 1990 as document number 90-287592, in Cook County, Illinois.

PLAT OF SURVEY

TAX DIVISION MAP

#32

STONELAKE SURVEY CO., LTD.
REGISTERED LAND SURVEYORS
11659 S. MAYFIELD AVENUE
WORTH ILLINOIS 60482
PHONE 388-1010



TAX PARCEL ONE: THE WEST 65.00 FEET (MEASURED PERPENDICULAR TO THE WEST LINE) OF LOT 1 IN ALDI SUBDIVISION, BEING A SUBDIVISION OF PART OF THE NORTHWEST 1/4 OF SECTION 18, TOWNSHIP 37 NORTH, RANGE 13, EAST OF THE THIRD PRINCIPAL MERIDIAN, ACCORDING TO THE PLAT THEREOF RECORDED JUNE 18, 1950 AS DOCUMENT NUMBER 90-207592, IN COOK COUNTY, ILLINOIS.

TAX PARCEL TWO: THE WEST 65.00 FEET (MEASURED PERPENDICULAR TO THE WEST LINE) OF LOT 2 IN ALDI SUBDIVISION, BEING A SUBDIVISION OF PART OF THE NORTHWEST 1/4 OF SECTION 18, TOWNSHIP 37 NORTH, RANGE 13, EAST OF THE THIRD PRINCIPAL MERIDIAN, ACCORDING TO THE PLAT THEREOF RECORDED JUNE 18, 1950 AS DOCUMENT NUMBER 90-207592, IN COOK COUNTY, ILLINOIS.

TAX PARCEL THREE: LOT 2 (EXCEPT THE WEST 65.00 FEET, MEASURED PERPENDICULAR TO THE WEST LINE THEREOF) IN ALDI SUBDIVISION, BEING A SUBDIVISION OF PART OF THE NORTHWEST 1/4 OF SECTION 18, TOWNSHIP 37 NORTH, RANGE 13, EAST OF THE THIRD PRINCIPAL MERIDIAN, ACCORDING TO THE PLAT THEREOF RECORDED JUNE 18, 1950 AS DOCUMENT NUMBER 90-207592, IN COOK COUNTY, ILLINOIS.

TAX PARCEL FOUR: LOT 3 (EXCEPT THE WEST 65.00 FEET MEASURED PERPENDICULAR TO THE WEST LINE THEREOF) IN ALDI SUBDIVISION, BEING A SUBDIVISION OF PART OF THE NORTHWEST 1/4 OF SECTION 18, TOWNSHIP 37 NORTH, RANGE 13, EAST OF THE THIRD PRINCIPAL MERIDIAN, ACCORDING TO THE PLAT THEREOF RECORDED JUNE 18, 1950 AS DOCUMENT NUMBER 90-207592, IN COOK COUNTY, ILLINOIS.

AREAS OF TAX PARCELS

TAX PARCEL ONE	= 11,344 SQUARE FEET
TAX PARCEL TWO	= 29,305 SQUARE FEET
TAX PARCEL THREE	= 42,431 SQUARE FEET
TAX PARCEL FOUR	= 50,760 SQUARE FEET

STATE OF ILLINOIS
COUNTY OF COOK

STONELAKE SURVEY CO., LTD. HEREBY CERTIFIES THAT
WE HAVE SURVEYED THE ABOVE DESCRIBED PROPERTY
AND HAVE PREPARED THE HEREIN ODDMAN PLAT FOR
TAX DIVISION PURPOSES. ALL OTHERS ARE ON
FEET AND DECIMAL PARTS THEREOF CORRECT AT 62"
TOLERANCE.

DATED AT WORTH, ILLINOIS THIS 26 DAY OF JUNE,
1960.

STONELAKE SURVEY CO., LTD.

TELEPHONE REGISTERED LAND SURVEYOR #1702

#32 P. 1 of 3

ADDRESS _____
SURVEYED FOR JOHN POWELL
ORDERED BY _____
ORDER NO. 324-701

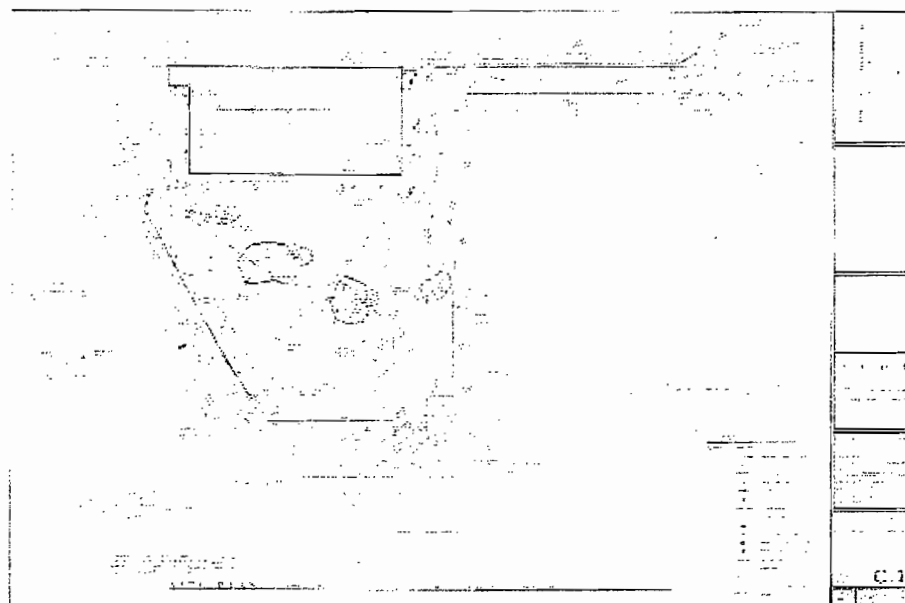
NO MEASUREMENTS ARE TO BE ASSUMED BY SCALE



24181010980000 07/15/2007



24181011000000 07/16/2007



Section IX, Financial Feasibility
Criterion 1120.130 – Financial Viability Waiver

The project will be funded entirely with cash. A copy of DaVita's 2013 10-K Statement evidencing sufficient internal resources to fund the project was previously submitted with the application for Project No. 14-016.

Section X, Economic Feasibility Review Criteria
Criterion 1120.140(a), Reasonableness of Financing Arrangements

Attached at Attachment – 39A is a letter from Arturo Sida, Assistant Corporate Secretary of DaVita HealthCare Partners, Inc. attesting that the total estimated project costs will be funded entirely with cash.

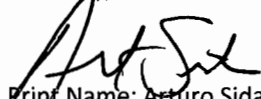
Kathryn Olson
Chair
Illinois Health Facilities and Services Review Board
525 West Jefferson Street, 2nd Floor
Springfield, Illinois 62761

Re: Reasonableness of Financing Arrangements

Dear Chair Olson:

I hereby certify under penalty of perjury as provided in § 1-109 of the Illinois Code of Civil Procedure, 735 ILCS 5/1-109 and pursuant to 77 Ill. Admin. Code § 1120.140(a) that the total estimated project costs and related costs will be funded in total with cash and cash equivalents.

Sincerely,



Print Name: Arturo Sida

Its: Assistant Corporate Secretary
DaVita HealthCare Partners Inc.

Subscribed and sworn to me

This ____ day of _____, 2014

See Attached

Notary Public

State of California

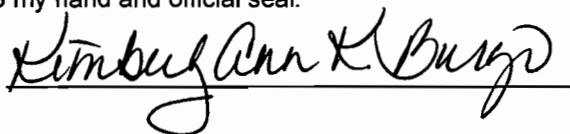
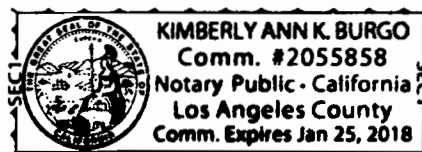
County of Los AngelesOn April 3, 2014 before me, Kimberly Ann K. Burgo, Notary Public
(here insert name and title of the officer)personally appeared Arturo Sida

who proved to me on the basis of satisfactory evidence to be the person(s) whose name(s) is/are subscribed to the within instrument and acknowledged to me that he/she/they executed the same in his/her/their authorized capacity(ies), and that by his/her/their signature(s) on the instrument the person(s), or the entity upon behalf of which the person(s) acted, executed the instrument.

I certify under PENALTY OF PERJURY under the laws of the State of California that the foregoing paragraph is true and correct.

WITNESS my hand and official seal.

Signature

(Seal)

OPTIONAL INFORMATION

Law does not require the information below. This information could be of great value to any person(s) relying on this document and could prevent fraudulent and/or the reattachment of this document to an unauthorized document(s)

DESCRIPTION OF ATTACHED DOCUMENT

Title or Type of Document: Secretary's Certificate - Ltr to K. Olson re Reasonableness of Financing ArrangementsDocument Date: April 3, 2014 Number of Pages: one (1)Signer(s) if Different Than Above: No

Other Information: _____

CAPACITY(IES) CLAIMED BY SIGNER(S)

Signer's Name(s): Arturo Sida☐ Individual☒ Corporate Officer

(Title(s))

☐ Partner☐ Attorney-in-Fact☐ Trustee☐ Guardian/Conservator☒ Other: Assistant Corporate Secretary

SIGNER IS REPRESENTING:

Name of Person(s) or Entity(ies): DaVita HealthCare Partners Inc.

Section X, Economic Feasibility Review Criteria
Criterion 1120.140(b), Conditions of Debt Financing

This project will be funded in total with cash and cash equivalents. Accordingly, this criterion is not applicable.

Section X, Economic Feasibility Review Criteria
Criterion 1120.140(c), Reasonableness of Project and Related Costs

1. The Cost and Gross Square Feet by Department is provided in the table below.

COST AND GROSS SQUARE FEET BY DEPARTMENT OR SERVICE									
Department (list below)	A	B	C	D	E	F	G	H	Total Cost (G + H)
	Cost/Square Foot New	Mod.	Gross Sq. Ft. New Circ.*		Gross Sq. Ft. Mod. Circ.*		Const. \$ (A x C)	Mod. \$ (B x E)	
ESRD		\$138.09			7,423			\$1,025,000	\$1,025,000
Contingency		\$20.02			7,423			\$148,625	\$148,625
TOTALS		\$158.11			7,423			\$1,173,625	\$1,173,625
* Include the percentage (%) of space for circulation									

2. As shown in Table 1120.310(c) below, the project costs are below the State Standard.

Table 1120.310(c)			
	Proposed Project	State Standard	Above/Below State Standard
Modernization Contracts & Contingencies	\$1,173,625	\$178.33 per gsf x 7,423 gsf = \$1,323,744	Below State Standard
Contingencies	\$148,625	10-15% of Modernization Contracts = 10-15% x \$1,025,000 = \$102,500 - \$153,750	Meets State Standard
Architectural/Engineering Fees	\$86,000	6.90% - 10.36% x (Modernization Costs + Contingencies) = 6.90% - 10.36% x (\$1,025,000 + \$148,625) = 6.90% - 10.36% x \$1,173,625 = \$80,980 - \$121,588	Meets State Standard
Consulting and Other Fees	\$53,500	No State Standard	No State Standard
Moveable Equipment	\$595,000	\$39,945 per station x 16 stations \$39,945 x 16 = \$639,120	Below State Standard

Section X, Economic Feasibility Review Criteria
Criterion 1120.310(d), Projected Operating Costs

Operating Expenses: \$3,634,537

Treatments: 14,976

Operating Expense per Treatment: \$242.69

Section X, Economic Feasibility Review Criteria
Criterion 1120.310(e), Total Effect of Project on Capital Costs

Capital Costs:

Depreciation: \$157,540

Amortization: \$ 10,088

Total Capital Costs: \$167,628

Treatments: 14,976

Capital Costs per Treatment: \$11.19

Section XI, Safety Net Impact Statement

1. This criterion is required for all substantive and discontinuation projects. DaVita HealthCare Partners Inc. and its affiliates are safety net providers of dialysis services to residents of the State of Illinois. DaVita is a leading provider of dialysis services in the United States and is committed to innovation, improving clinical outcomes, compassionate care, education and Kidney Smarting patients, and community outreach. A copy of DaVita's 2012 Community Care report, which details DaVita's commitment to quality, patient centric focus and community outreach, was previously submitted on April 24, 2014 as part of the Applicants' application for Proj. No. 14-016. DaVita has taken on many initiatives to improve the lives of patients suffering from CKD and ESRD. These programs include the Kidney Smart, IMPACT, CathAway, and transplant assistance programs. Furthermore, DaVita is an industry leader in the rate of fistula use and had the lowest day-90 catheter rates among large dialysis providers in 2013. Its commitment to improving clinical outcomes directly translated into 7% reduction in hospitalizations among DaVita patients, the monetary result of which was \$1.5 Billion in savings to the health care system and the American taxpayer since 2010.
2. The proposed project will not impact the ability of other health care providers or health care systems to cross-subsidize safety net services. As shown in Table 1110.1430(b), average utilization at existing dialysis facilities within 30 minutes normal travel time of the Proposed Facility is currently 71%. Of particular note, the utilization of all facilities within 20 minutes of the proposed Chicago Ridge Dialysis is 76%. Dr. Pallath has identified 179 patients from her practice who are suffering from Stage 4 or 5 CKD, who all reside within an approximate 20 minute commute of the proposed facility. Thus, approximately 113 patients will be referred to the Proposed Facility within 12 to 24 months. This represents a utilization rate which exceeds the State's 80% standard. DaVita has taken a conservation approach in requesting a 16 station facility and will expand in the future as utilization increases. As such, the proposed facility is necessary to allow existing facilities to operate at their optimum capacity while at the same time accommodating the growing demand for dialysis services. Accordingly, the proposed dialysis facility will not impact other general health care providers' ability to cross-subsidize safety net services.
3. The proposed project is for the establishment of Chicago Ridge Dialysis. As such, this criterion is not applicable.

Safety Net Information per PA 96-0031			
CHARITY CARE			
	2011	2012	2013
Charity (# of patients)	96	152	187
Charity (cost in dollars)	\$830,580	\$1,199,657	\$2,175,940
MEDICAID			
	2011	2012	2013
Medicaid (# of patients)	729	651	679
Medicaid (revenue)	\$14,585,645	\$11,387,229	\$10,371,416

Section XII, Charity Care Information

The table below provides charity care information for all dialysis facilities located in the State of Illinois that are owned or operated by the Applicants.

CHARITY CARE			
	2011	2012	2013
Net Patient Revenue	\$219,396,657	\$228,403,979	\$244,115,132
Amount of Charity Care (charges)	\$830,580	\$1,199,657	\$2,175,940
Cost of Charity Care	\$830,580	\$1,199,657	\$2,175,940

Appendix 1 – Physician Referral Letter

Attached as Appendix 1 is the physician referral letter from Dr. Sreya Pallath projecting 113 pre-ESRD patients will be referred to Chicago Ridge Dialysis within the next 12 to 24 months.

Sreya Pallath, M.D.
J.R. Nephrology & Associates, P.C.
4542 W. 95th Street
Oak Lawn, Illinois 60453

Kathryn J. Olson
Chair
Illinois Health Facilities and Services Review Board
525 West Jefferson Street, 2nd Floor
Springfield, Illinois 62761

Dear Chair Olson:

I am pleased to support DaVita's establishment of Chicago Ridge Dialysis. The proposed 16-station chronic renal dialysis facility, to be located at 10511 South Harlem Avenue, Worth, Illinois 60482 will directly benefit my patients.

DaVita's proposed facility will improve access to necessary dialysis services in the Chicago Ridge / Worth community. DaVita is well-positioned to provide these services, as it delivers life sustaining dialysis for residents of similar communities throughout the country and abroad. It has also invested in many quality initiatives to improve its patients' health and outcomes.

The site of the proposed facility is close to Interstate 294 (I-294) and will provide better access to patients residing in the south and southwest suburbs, as well as the far southwest area of the city of Chicago. Utilization of facilities within 20 minutes of the proposed facility was 76.6%, according to December 31, 2013 reported census data.

I have identified 179 patients from my practice who are suffering from Stage 4 or 5 CKD, who all reside within an approximate 20 minute commute of the proposed facility. Conservatively, I predict at least 113 of these patients will progress to dialysis within the next 12 to 24 months. My large patient base, the significant utilization at nearby facilities, and the present 83-station need identified in Health Service Area 7 demonstrate considerable demand for this facility.

A list of patients who have received care at existing facilities in the area over the past 4 years is provided at Attachment – 1. A list of new patients my practice has referred for in-center hemodialysis for the past 2 years is provided at Attachment – 2. The list of zip codes for the 179 pre-ESRD patients previously referenced is provided at Attachment – 3.

These patient referrals have not been used to support another pending or approved certificate of need application. The information in this letter is true and correct to the best of my knowledge.

DaVita is a leading provider of dialysis services in the United States and I support the proposed establishment of Chicago Ridge Dialysis.

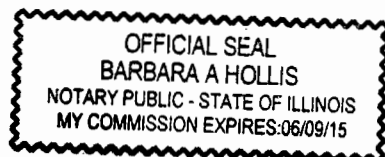
Sincerely,



Sreya Pallath, M.D.
Nephrologist
J.R. Nephrology & Associates, P.C.
4542 W. 95th Street
Oak Lawn, Illinois 60453

Subscribed and sworn to me
This 15th day of April, 2014

Notary Public: 



Attachment 1
Historical Patient Utilization

Stony Creek Dialysis							
2010		2011		2012		2013	
Initials	Zip Code	Initials	Zip Code	Initials	Zip Code	Initials	Zip Code
RA	60453	RA	60453	RA	60453	RA	60453
JA	60805	JA	60805	EA	60459	EA	60459
EA	60805	EA	60459	JA	60638	JA	60638
MA	60465	JA	60638	RB	60803	RB	60803
EA	60459	RB	60803	FB	60632	FB	60632
HB	60805	GB	60644	GB	60644	GB	60644
RB	60803	EC	60617	JC	60453	JC	60453
EC	60617	DD	60406	EC	60617	EC	60617
JC	60803	AA	60459	DD	60406	WD	60456
DC	60459	LB	60415	WD	60456	JB	60652
DD	60406	JB	60652	AA	60459	CB	60629
AA	60459	CB	60629	JB	60652	IB	60620
HA	60453	IB	60620	CB	60629	AB	60406
JB	60652	AB	60406	IB	60620	MC	60629
AB	60453	CB	46307	AB	60406	JD	60652
CB	60629	MC	60629	MC	60629	CD	60628
IB	60620	WC	60453	WC	60453	WD	60636
JB	60628	FC	60620	FC	60620	DD	60652
AB	60406	EC	60453	MD	60453	ZE	60629
LC	89107	MD	60453	JD	60652	JF	60457
MC	60629	JD	60652	CD	60628	PG	60629
JC	60803	CD	60628	DD	60406	EG	60482
WC	60453	DD	60406	WD	60636	RG	60632
DC	60459	WD	60636	BD	60463	BG	60453
FC	60620	DD	60652	DD	60652	RG	60620
EC	60453	ZE	60629	ZE	60629	JH	60620
JD	60652	NF	60629	DF	60459	LH	60453
LD	60803	OF	60638	JF	60457	RI	60652
MD	60638	DF	60459	PG	60629	JJ	60453
CD	60628	PG	60629	EG	60482	AJ	60652
DD	60406	LG	60487	RG	60632	JJ	60629
WD	60636	RG	60632	BG	60453	RK	60459
DD	60652	SG	60803	SG	60803	WK	60638
ZE	60629	RG	60465	VG	60453	HL	60453
OF	60638	VG	60453	RG	60620	GM	60453
DF	60459	JH	60620	JH	60620	FM	60457
PG	60629	WH	60453	JH	46405	YM	60632
LG	60652	SH	60620	SH	60620	DN	60453
LG	60487	LH	60453	LH	60453	EN	60455
RG	60632	RJ	60629	RI	60652	PO	60453

Stony Creek Dialysis, CONTINUED							
2010		2011		2012		2013	
Initials	Zip Code	Initials	Zip Code	Initials	Zip Code	Initials	Zip Code
VG	60453	JJ	60453	RJ	60629	KP	60456
MG	60453	AJ	60652	JJ	60453	SP	60455
MG	60652	JJ	60629	AJ	60652	AP	60455
JH	60620	RJ	60803	JJ	60629	GR	60459
WH	60453	EK	60453	RJ	60803	MR	60465
SH	60620	RK	60459	EK	60453	RS	60629
LH	60453	WK	60638	RK	60459	BS	60652
JJ	60453	DM	60459	AK	60465	AS	60456
JJ	60652	GM	60453	WK	60638	LS	60805
JJ	60629	FM	60457	HL	60453	RS	60491
RJ	60803	AM	60638	GM	60453	WS	60453
EK	60453	DM	60805	FM	60457	DT	60638
RK	60459	DN	60453	YM	60632	GV	60459
WK	60638	EN	60455	DM	60805	LW	60652
RK	60638	JN	60453	RM	60805	JW	60415
PL	60455	JO	60453	MM	60453	GW	60609
IL	60457	PO	60453	DN	60453	WW	60620
RL	60629	KP	60456	EN	60455	EW	60453
DM	60459	BP	60453	JO	60453	DW	60458
CM	60638	AP	60455	PO	60453	WY	60453
GM	60453	JR	60453	KP	60456	JZ	60459
KM	60636	RS	60629	SP	60455	JW	60428
LM	60803	BS	60652	AP	60455	IO	60453
FM	60457	AS	60456	GR	60459	MT	60652
DM	60805	ES	60629	JR	60453	GW	60620
HM	60463	LS	60805	MR	60465	MR	60619
JN	60459	RS	60491	RS	60629	JC	60458
DN	60453	WS	60453	BS	60652	DF	60655
JO	60643	GV	60459	AS	60456	MM	60459
JO	60453	RV	60453	SS	60453	AM	60455
JP	60453	LW	60652	CS	60453	MK	60453
BP	60453	JW	60415	LS	60805	JH	60455
AP	60455	GW	60609	RS	60491	GT	60453
JR	60453	WW	60620	WS	60453	WB	60453
BS	60652	JW	60629	DT	60638	CH	60638
AS	60456	MW	60085	GV	60459	PJ	60453
ES	60629	EW	60453	RV	60453	DG	60457
LS	60805	DW	60458	LW	60652	MT	60652
RS	60491	HY	60453	JW	60415	BD	60459
WS	60453	JZ	60459	GW	60609		
MV	60403	KZ	60445	WW	60620		
RV	60453			EW	60453		
LW	60652			DW	60458		
GW	60609			WY	60453		

Stony Creek Dialysis, CONTINUED					
2010		2011	2012		2013
Initials	Zip Code		Initials	Zip Code	
JW	60453		JZ	60459	
WW	60620				
DW	60458				
HY	60453				
JZ	60459				
KZ	60445				

Beverly Dialysis							
2010		2011		2012		2013	
Initials	Zip Code	Initials	Zip Code	Initials	Zip Code	Initials	Zip Code
LF	60628	LF	60628	RM	60620	SG	60629
OJ	60609	RM	60620	SG	60629	EC	60620
RM	60620	SG	60629	EC	60620	WG	60652
SG	60629	EC	60620	WG	60652	EH	60619
EC	60620	WG	60652	EH	60619	MH	60609
WG	60652	EH	60619	MH	60609	BH	60620
EH	60619	MH	60609	BH	60620	AJ	60620
MH	60609	BH	60620	AJ	60620	DR	60620
BH	60620	AJ	60620	DR	60620	AS	60620
AJ	60620	DR	60620	AS	60620	AF	60619
DR	60620	AS	60620	AF	60619	BA	60620
AS	60620	AF	60619	BA	60620	AB	60620
RB	60803	AH	60629	AB	60620	BG	60620
SC	60465	JM	60619	BG	60620	DG	60478
MC	60629	RR	60629	DG	60478	SM	60629
AF	60619	WS	60620	BG	60652	KM	60636
WG	60643	BA	60620	SM	60629	CR	60620
AH	60629	AB	60620	KM	60636	BT	60620
CL	60628	BG	60620	CR	60620	IW	60628
SM	60617	DG	60478	BT	60620	AB	60628
JM	60619	BG	60652	IW	60628	TB	60620
LM	60803	SM	60629	SA	60636	GC	60629
RR	60629	KM	60636	AB	60628	RJ	60620
GS	60617	CR	60620	TB	60620	SJ	60628
WS	60620	BT	60620	GC	60629	KP	60620
BA	60620	IW	60628	RJ	60620	ST	60620
AB	60620	SA	60636	SJ	60628	VB	60636
BG	60620	AB	60628	KP	60620	WK	60620
DG	60478	TB	60620	MR	60619	RL	60619
BG	60652	JC	60629	JS	60628	CM	60620
SM	60629	GC	60629	GS	60636	LN	60620
KM	60636	GH	60629	ST	60620	FP	60620
CR	60620	KH	60652	BD	60621	RP	60652
BT	60620	MJ	60619	VB	60636	GR	60643
IW	60628	RJ	60620	WK	60620	MR	60610
AH	60608	SJ	60628	RL	60619	ER	60628
BA	60649	WK	60628	CM	60620	JT	60620
EH	60629	WK	60629	LN	60620	WT	60620
AK	60617	ML	60652	FP	60620	RT	60629
DR	60620	LM	60803	RP	60652	CT	60620
		RN	60628	GR	60643	AW	60458
		PN	60643	MR	60610	TC	60652

Beverly Dialysis, CONTINUED						
2010	2011		2012		2013	
	Initials	Zip Code	Initials	Zip Code	Initials	Zip Code
	KP	60620	ER	60628	LG	60629
	CR	60643	RS	60620	AJ	60652
	LR	60628	LS	60805	SJ	60636
	MR	60619	JT	60620	MK	60453
	JS	60628	WT	60620	HM	60617
	GS	60636	RT	60629	LS	60620
	ST	60620	CT	60620	BT	60620
	MT	60652	AW	60458	BA	60649
	LW	60620	BA	60649	EH	60629
	BA	60649	EH	60629	AK	60617
	EH	60629	AK	60617	DR	60620
	AK	60617	DR	60620	AC	60643
	DR	60620			SR	60628
					HL	60643
					DG	60620
					HD	60617
					LJ	60620
					EM	60620
					RA	60620
					OS	60628
					JI	60628

West Lawn Dialysis							
2010		2011		2012		2013	
Initials	Zip Code	Initials	Zip Code	Initials	Zip Code	Initials	Zip Code
N/A	N/A	FB	60636	FB	60636	FB	60636
		EC	60637	EC	60637	EC	60637
		MG	60632	MG	60632	MG	60632
		RJ	60629	RJ	60629	RJ	60629
		MJ	60620	MJ	60620	MJ	60620
		WK	60629	WK	60629	WK	60629
		EM	60652	EM	60652	EM	60652
		MR	60652	MR	60652	MR	60652
		IS	60629	IS	60629	IS	60629
				MA	60629	MA	60629
				AB	60629	AB	60629
				AB	60629	AB	60629
				DB	60621	DB	60621
				MR	60632	MR	60632
				BD	60629	BD	60629
				MD	60501	MD	60501
				PF	60629	PF	60629
				GH	60629	GH	60629
				HJ	60636	HJ	60636
				MJ	60629	MJ	60629
				EN	60632	EN	60632
				RO	60632	RO	60632
				HR	60501	HR	60501
				MR	60632	MR	60632
				AR	60629	AR	60629
				NR	60652	NR	60652
				MT	60652	MT	60652
				CV	60629	CV	60629
				BZ	60629	BZ	60629
						JA	60638
						SA	60629
						JB	60629
						UC	60632
						ZC	60652
						BF	60629
						GG	60632
						HG	60629
						BG	60632
						JH	60629
						KH	60629
						AM	60453
						MM	60805

West Lawn Dialysis, CONTINUED				
2010	2011	2012	2013	
			Initials	Zip Code
			LM	60632
			JM	60629
			SP	60619
			CP	60620
			SR	60652
			GA	60636
			DD	60632
			RJ	60619
			LP	60620
			AR	60632

Attachment 2
New Patients

Stony Creek Dialysis			
2012		2013	
Initials	Zip Code	Initials	Zip Code
FB	60632	JW	60428
BZ	60629	IO	60453
WD	60456	MT	60652
BD	60463	GW	60620
JF	60457	MR	60619
EG	60482	JC	60458
JC	60453	DF	60655
BG	60453	MM	60459
RG	60620	AM	60455
RI	60652	MK	60453
EK	60453	JH	60455
AK	60465	GT	60453
MM	60457	WB	60453
RM	60805	CH	60638
MM	60453	PJ	60453
SP	60455	DG	60457
GR	60459	MT	60652
SS	60453	BD	60459
CS	60453		
HL	60411		
WY	60453		
HL	60453		
YM	60632		

Beverly Dialysis			
2012		2013	
Initials	Zip Code	Initials	Zip Code
BD	60621	TC	60652
VB	60636	LG	60629
WK	60620	AJ	60652
RL	60619	SJ	60636
CM	60620	MK	60453
LN	60620	HM	60617
FP	60620	LS	60620
RP	60652	BT	60620
GR	60643	AC	60643
MR	60610	SR	60628
ER	60628	HL	60643
CT	60620	DG	60620
AW	60458	HD	60617
		LJ	60620
		EM	60620
		RA	60620
		OS	60628
		JI	60628

West Lawn Dialysis			
2012		2013	
Initials	Zip Code	Initials	Zip Code
MA	60629	JA	60638
AB	60629	SA	60629
AB	60629	JB	60629
DB	60621	UC	60632
MR	60632	ZC	60652
BD	60629	BF	60629
MD	60501	GG	60632
PF	60629	HG	60629
GH	60629	BG	60632
HJ	60636	JH	60629
MJ	60629	KH	60629
EN	60632	AM	60453
RO	60632	MM	60805
HR	60501	LM	60632
MR	60632	JM	60629
AR	60629	SP	60619
NR	60652	CP	60620
MT	60652	SR	60652
CV	60629	GA	60636
BZ	60629	DD	60632
		RJ	60619
		LP	60620
		AR	60632

Attachment 3
Pre-ESRD Patients

Zip Code	Total
60406	1
60415	3
60445	7
60452	4
60453	40
60455	5
60456	5
60457	6
60458	4
60459	10
60462	4
60463	6
60464	2
60465	2
60467	3
60477	5
60482	3
60501	3
60525	2
60527	2
60643	9
60652	20
60655	13
60803	10
60805	10
Total	179

Appendix 2 – Time & Distance Determination

Attached as Appendix 2 are the distance and normal travel time from the proposed facility to all existing dialysis facilities in the GSA, as determined by MapQuest.



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Property Record for 10511 S Harlem Avenue, Worth, IL 60482

Information for the Retail property located at 10511 S Harlem Avenue, Worth, IL 60482 includes data gathered from Cook County tax records, public records data providers and LoopNet historical listing and sales records.

Search our Large Inventory of Commercial and Investment Properties Available for Sale and Lease.

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LoopNet Property Records

LoopNet Property Records display available information such as historical listings, property details, property tax records, property deeds, owners, mortgages, tenants, and more. Information is aggregated from the LoopNet marketplace, LoopNet research, leading independent data providers, Cook County tax records, and LoopNet members.

Retail Property Record

10511 S Harlem Avenue, Worth, IL 60482

[Summary](#) [Stats & Trends](#) [Property](#) [Maps](#)

Summary



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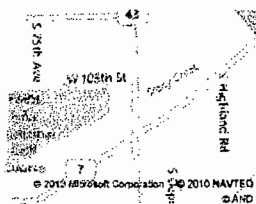
Property Details

[View Details](#)

Primary Property Type: Retail

Property Sub-type: Retail (Other)

Building Size:



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The information above has been obtained from sources believed reliable. While we do not doubt its accuracy we have not verified it and make no guarantee, warranty or representation about it. It is your responsibility to independently confirm its accuracy and completeness. Any projections, opinions, assumptions, or estimates used are for example only and do not represent the current or future performance of the property. The value of this transaction to you depends on tax and other factors which should be evaluated by your tax, financial, and legal advisors. You and your advisors should conduct a careful, independent investigation of the property to determine to your satisfaction the suitability of the property for your needs.

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mapquest

Notes

FMC Bolingbrook Dialysis Center

Trip to:

538 E Boughton Rd

Bolingbrook, IL 60440-2181

17.52 miles / 26 minutes



[10451-10548] S Harlem Ave, Palos Hills, IL 60465



1. Start out going north on S Harlem Ave / IL-43 toward W 105th St. [Map](#)

1.3 Mi

1.3 Mi Total



2. Merge onto US-20 W / US-12 W / W 95th St toward I-294-TOLL N. [Map](#)

0.5 Mi

1.8 Mi Total



3. Merge onto I-294 N toward Wisconsin (Portions toll). [Map](#)

5.7 Mi

7.5 Mi Total



4. Merge onto I-55 S toward St Louis. [Map](#)

6.9 Mi

14.5 Mi Total



5. Take the North Lemont Rd exit, EXIT 271B. [Map](#)

0.3 Mi

14.7 Mi Total



6. Merge onto Lemont Rd. [Map](#)

0.7 Mi

15.4 Mi Total



7. Take the 3rd left onto 87th St. [Map](#)

1.0 Mi

87th St is 0.2 miles past Woodcrest Dr

16.4 Mi Total

If you reach 86th St you've gone about 0.1 miles too far



8. 87th St becomes E Boughton Rd. [Map](#)

1.1 Mi

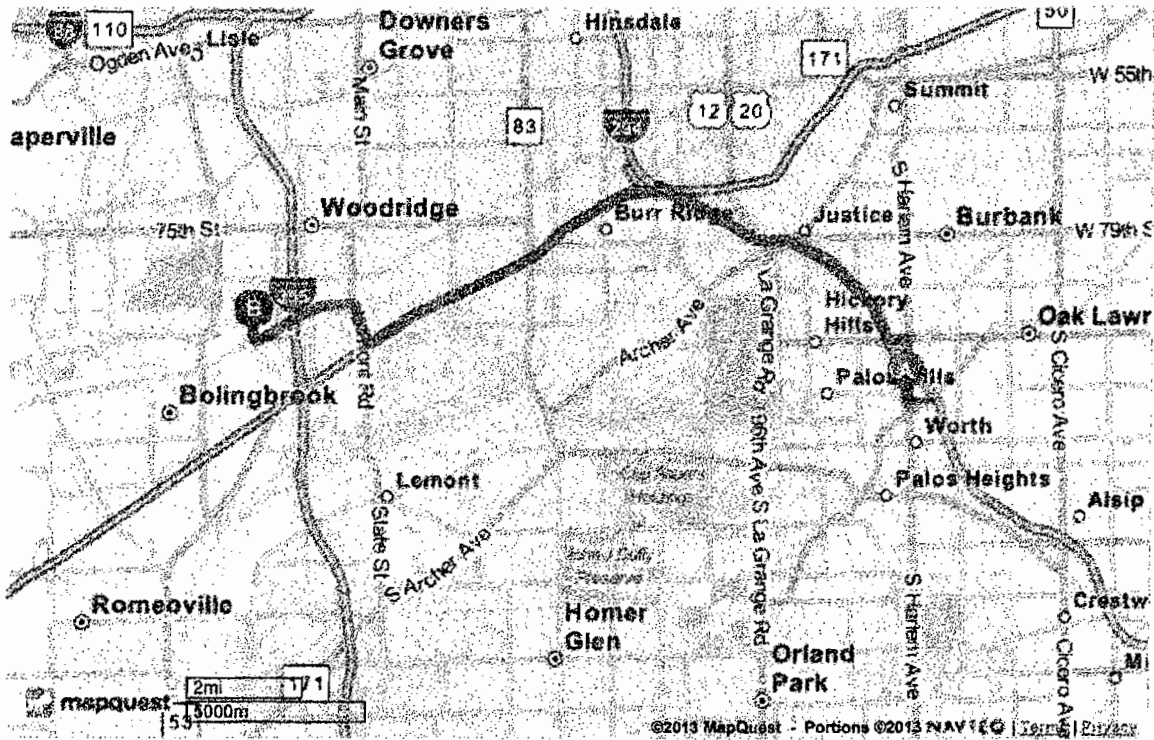
17.5 Mi Total



538 E Boughton Rd, Bolingbrook, IL 60440-2181

Total Travel Estimate: 17.52 miles - about 26 minutes

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Notes

Silver Cross Renal Center

Trip to:

1890 Silver Cross Blvd

New Lenox, IL 60451-9508

17.73 miles / 31 minutes



[10451-10548] S Harlem Ave, Palos Hills, IL 60465



1. Start out going **south** on **S Harlem Ave / IL-43** toward **SouthWest Hwy**. [Map](#)

0.1 Mi

0.1 Mi Total



7

2. Take the **1st right** onto **SouthWest Hwy / IL-7**. [Map](#)

6.0 Mi

6.1 Mi Total

Brooklyn Pizza is on the corner

If you are on S Harlem Ave and reach W 107th St you've gone a little too far



7

3. Turn **slight right** onto **W 143rd St / IL-7**. [Map](#)

1.6 Mi

7.8 Mi Total

The Irish Patriot is on the corner



4. Turn **left** onto **Wolf Rd / IL-7**. Continue to follow **Wolf Rd**. [Map](#)

3.9 Mi

11.7 Mi Total

Wolf Rd is 0.2 miles past Deer Haven Ln

CVS Pharmacy is on the corner

If you reach Compton Ct you've gone about 0.1 miles too far



WEST
6

5. Turn **right** onto **US-6 / SouthWest Hwy**. Continue to follow **US-6 W**. [Map](#)

5.6 Mi

17.2 Mi Total

US-6 W is 0.2 miles past Brook Hill Dr

If you reach 175th St you've gone about 0.1 miles too far



6. Turn **left** onto **Silver Cross Blvd**. [Map](#)

0.4 Mi

17.6 Mi Total

Silver Cross Blvd is 1.0 mile past N Cedar Rd

If you reach Spring Creek St you've gone about 0.2 miles too far



7. Make a **U-turn** onto **Silver Cross Blvd**. [Map](#)

0.2 Mi

17.7 Mi Total

If you reach Abraham Dr you've gone about 0.6 miles too far



8. **1890 SILVER CROSS BLVD** is on the **right**. [Map](#)

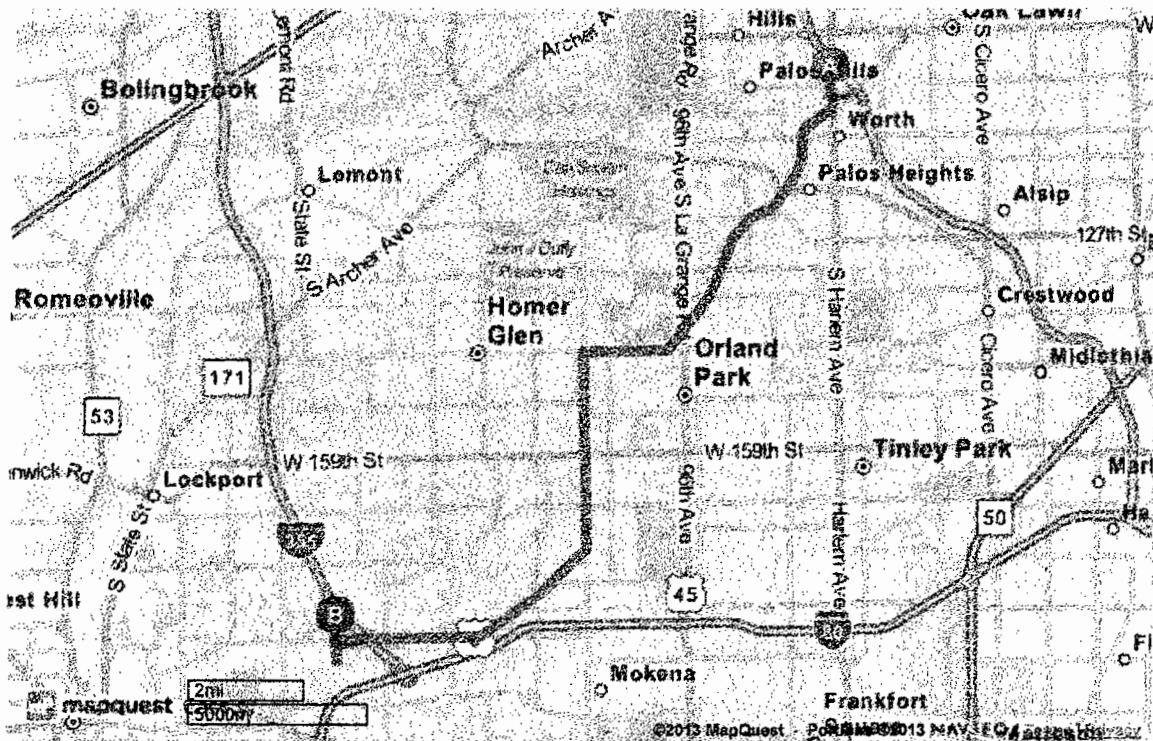
If you reach Maple Rd you've gone about 0.1 miles too far



1890 Silver Cross Blvd, New Lenox, IL 60451-9508

Total Travel Estimate: 17.73 miles - about 31 minutes

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Notes

USRC Oak Brook

Trip to:

1201 Butterfield Rd Ste B

Downers Grove, IL 60515-1074

19.40 miles / 26 minutes



[10451-10548] S Harlem Ave, Palos Hills, IL 60465



1. Start out going north on S Harlem Ave / IL-43 toward W 105th St. [Map](#)

1.3 Mi

1.3 Mi Total



2. Merge onto US-20 W / US-12 W / W 95th St toward I-294-TOLL N. [Map](#)

0.5 Mi

1.8 Mi Total



3. Merge onto I-294 N toward Wisconsin (Portions toll). [Map](#)

11.5 Mi

13.3 Mi Total



4. Merge onto I-88 W / IL-110 W / Ronald Reagan Memorial Tollway toward Aurora (Portions toll). [Map](#)

5.5 Mi

18.8 Mi Total



5. Take the Highland Ave exit. [Map](#)

0.2 Mi

19.0 Mi Total



6. Keep left to take the ramp toward Downers Grove / Northwestern College / Keller College. [Map](#)

0.04 Mi

19.1 Mi Total



7. Stay straight to go onto Butterfield Rd. [Map](#)

0.3 Mi

19.4 Mi Total



8. 1201 BUTTERFIELD RD STE B is on the left. [Map](#)

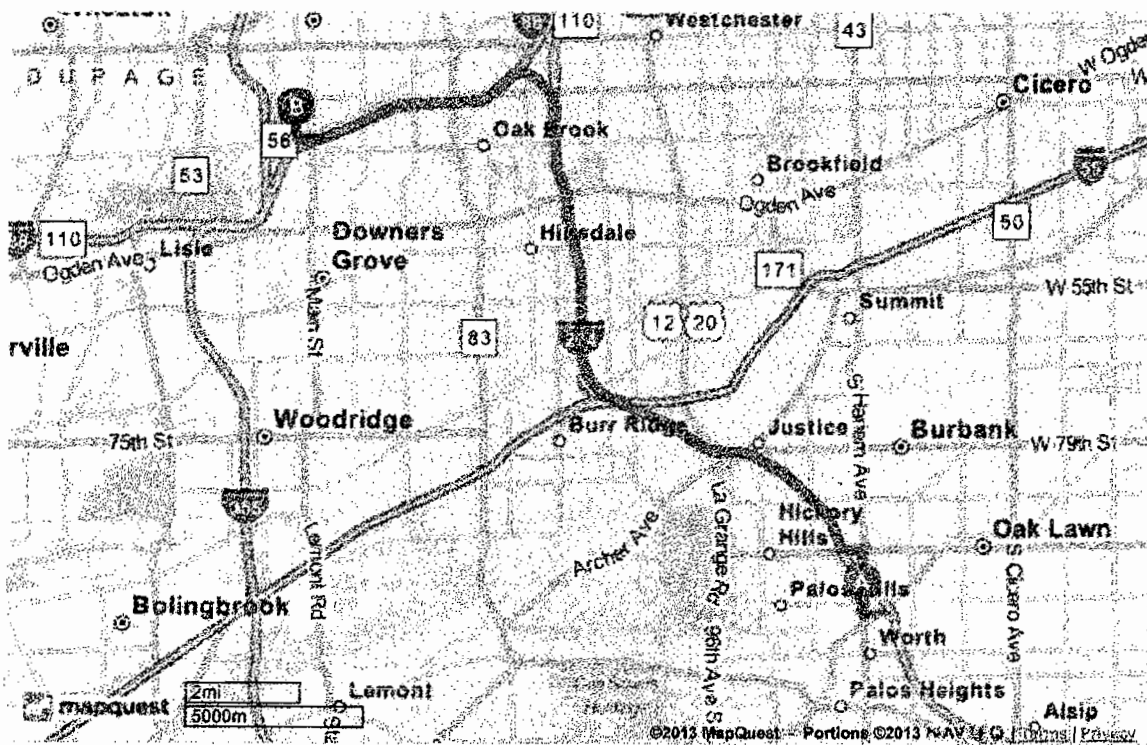
Your destination is 0.3 miles past Highland Ave
If you reach Downers Dr you've gone about 0.2 miles too far



1201 Butterfield Rd Ste B, Downers Grove, IL 60515-1074

Total Travel Estimate: 19.40 miles - about 26 minutes

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Notes

FMC Downers Grove

Trip to:

3825 Highland Ave

Downers Grove, IL 60515-1554

20.22 miles / 28 minutes



[10451-10548] S Harlem Ave, Palos Hills, IL 60465



1. Start out going north on **S Harlem Ave / IL-43** toward **W 105th St**. [Map](#)

1.3 Mi

1.3 Mi Total



2. Merge onto **US-20 W / US-12 W / W 95th St** toward **I-294-TOLL N**. [Map](#)

0.5 Mi

1.8 Mi Total



3. Merge onto **I-294 N** toward **Wisconsin** (Portions toll). [Map](#)

11.5 Mi

13.3 Mi Total



4. Merge onto **I-88 W / IL-110 W / Ronald Reagan Memorial Tollway** toward **Aurora** (Portions toll). [Map](#)

5.5 Mi

18.8 Mi Total



5. Take the **Highland Ave** exit. [Map](#)

0.2 Mi

19.0 Mi Total



6. Keep **left** to take the ramp toward **Downers Grove / Northwestern College / Keller College**. [Map](#)

0.04 Mi

19.1 Mi Total



7. Turn **left** onto **Highland Ave**. [Map](#)

1.1 Mi

20.2 Mi Total



8. **3825 HIGHLAND AVE** is on the **left**. [Map](#)

Your destination is just past Black Oak Dr

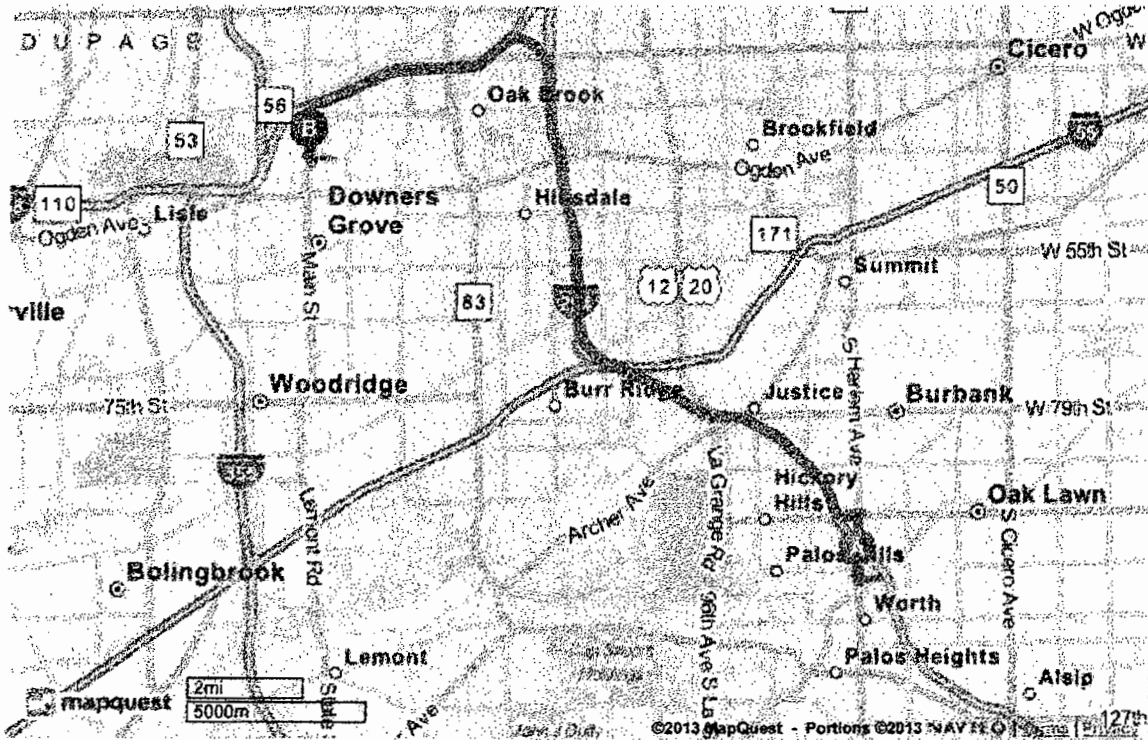
If you reach 39th St you've gone about 0.1 miles too far



3825 Highland Ave, Downers Grove, IL 60515-1554

Total Travel Estimate: 20.22 miles - about 28 minutes

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Notes

FMC Dialysis Services of Willowbrook

Trip to:

6300 Kingery Hwy Ste 408

Willowbrook, IL 60527-2271

13.13 miles / 19 minutes



[10451-10548] S Harlem Ave, Palos Hills, IL 60465



1. Start out going **north** on **S Harlem Ave / IL-43** toward **W 105th St**. [Map](#)

1.3 Mi

1.3 Mi Total



2. Merge onto **US-20 W / US-12 W / W 95th St** toward **I-294-TOLL N**. [Map](#)

0.5 Mi

1.8 Mi Total



3. Merge onto **I-294 N** toward **Wisconsin** (Portions toll). [Map](#)

5.7 Mi

7.5 Mi Total



4. Merge onto **I-55 S** toward **St Louis**. [Map](#)

3.1 Mi

10.7 Mi Total



5. Merge onto **IL-83 N** via **EXIT 274**. [Map](#)

2.4 Mi

13.1 Mi Total



6. Turn **left** onto **63rd St**. [Map](#)

0.01 Mi

*63rd St is 0.2 miles past Ridgemoor Dr W
Bank of America Banking Center - Route 83/63rd St is on the corner*

13.1 Mi Total



7. **6300 KINGERY HWY STE 408**. [Map](#)

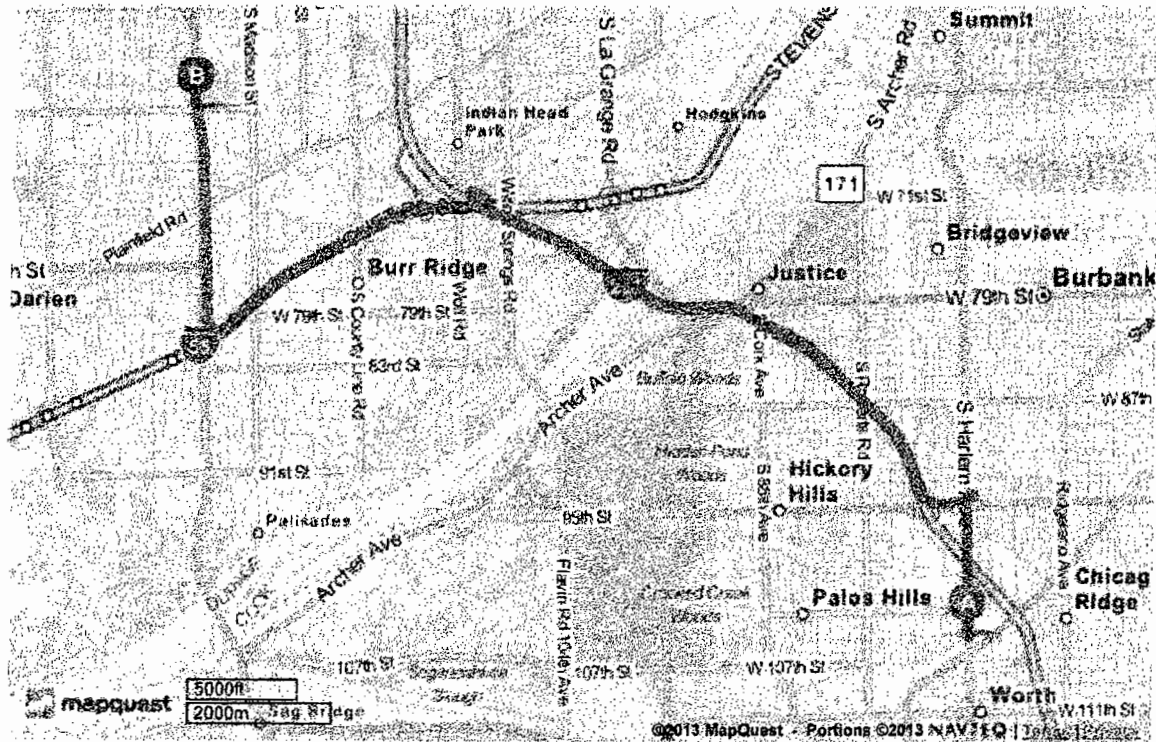
If you reach Americana Dr you've gone about 0.1 miles too far



6300 Kingery Hwy Ste 408, Willowbrook, IL 60527-2271

Total Travel Estimate: 13.13 miles - about 19 minutes

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Notes

Fresenius Medical Care -Lombard



Trip to:

1940 Springer Dr
Lombard, IL 60148-6419
21.05 miles / 30 minutes



[10451-10548] S Harlem Ave, Palos Hills, IL 60465

- 



1. Start out going north on **S Harlem Ave / IL-43** toward **W 105th St**. [Map](#) **1.3 Mi**

1.3 Mi Total
- 



2. Merge onto **US-20 W / US-12 W / W 95th St** toward **I-294-TOLL N**. [Map](#) **0.5 Mi**

1.8 Mi Total
- 



3. Merge onto **I-294 N** toward **Wisconsin (Portions toll)**. [Map](#) **11.5 Mi**

13.3 Mi Total
- 



4. Merge onto **I-88 W / IL-110 W / Ronald Reagan Memorial Tollway** toward **Aurora** (Portions toll). [Map](#) **5.5 Mi**

18.8 Mi Total
- 



5. Take the **Highland Ave** exit. [Map](#) **0.2 Mi**

19.0 Mi Total
- 


6. Keep right to take the ramp toward **Lombard / Chiropractic College**. [Map](#) **0.05 Mi**

19.1 Mi Total
- 

7. Turn **right** onto **Highland Ave**. [Map](#) **0.03 Mi**


19.1 Mi Total
- 


8. Merge onto **Butterfield Rd / IL-56 W** via the ramp on the **left**. [Map](#) **0.8 Mi**

19.9 Mi Total
- 


9. Turn **right** onto **Finley Rd**. [Map](#) **0.9 Mi**

20.8 Mi Total


Finley Rd is 0.2 miles past Downers Dr
- 

10. Turn **left** onto **Foxworth Blvd**. [Map](#) **0.1 Mi**

20.9 Mi Total

Foxworth Blvd is 0.1 miles past 22nd St
If you reach Oak Creek Dr you've gone about 0.2 miles too far
- 

11. Turn **right** onto **Springer Dr**. [Map](#) **0.1 Mi**

21.0 Mi Total
- 

12. **1940 SPRINGER DR** is on the **left**. [Map](#)

If you reach Oak Creek Dr you've gone about 0.1 miles too far

1940 Springer Dr, Lombard, IL 60148-6419

Total Travel Estimate: 21.05 miles - about 30 minutes

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Notes

FMC Elmhurst

Trip to:

133 E Brush Hill Rd

Elmhurst, IL 60126-5658

16.20 miles / 23 minutes



[10451-10548] S Harlem Ave, Palos Hills, IL 60465



1. Start out going **north** on **S Harlem Ave / IL-43** toward **W 105th St**. [Map](#)

1.3 Mi

1.3 Mi Total



2. Merge onto **US-20 W / US-12 W / W 95th St** toward **I-294-TOLL N**. [Map](#)

0.5 Mi

1.8 Mi Total



3. Merge onto **I-294 N** toward **Wisconsin (Portions toll)**. [Map](#)

13.1 Mi

15.0 Mi Total



4. Merge onto **IL-38 W / Roosevelt Rd**. [Map](#)

0.7 Mi

15.7 Mi Total



5. Take the **North York Road** ramp. [Map](#)

0.3 Mi

15.9 Mi Total



6. Turn **slight left** onto **E Brush Hill Rd**. [Map](#)

0.3 Mi

16.2 Mi Total



7. **133 E BRUSH HILL RD**. [Map](#)

Your destination is 0.2 miles past Fronza Pky

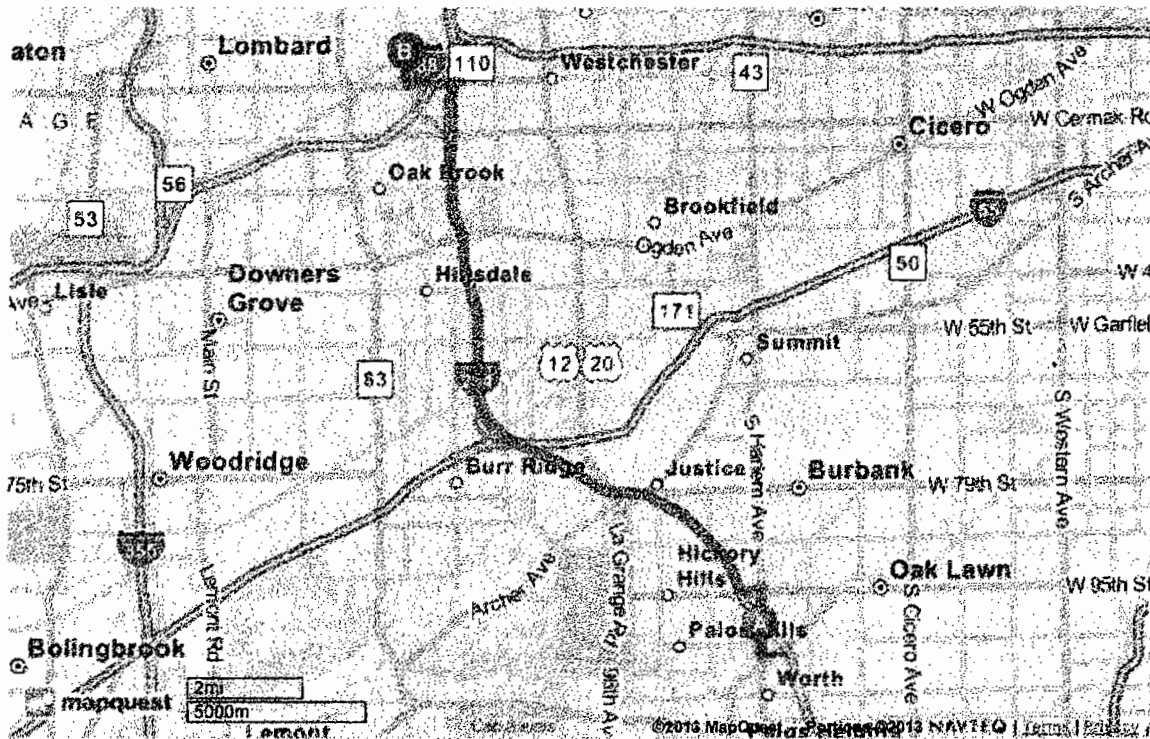
If you reach S Euclid Ave you've gone about 0.1 miles too far



133 E Brush Hill Rd, Elmhurst, IL 60126-5658

Total Travel Estimate: 16.20 miles - about 23 minutes

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Notes

FMC - LaGrange Dialysis Center

Trip to:

2400 Wolf Rd Ste 101a

Westchester, IL 60154-5635

14.21 miles / 21 minutes



[10451-10548] S Harlem Ave, Palos Hills, IL 60465



1. Start out going north on S Harlem Ave / IL-43 toward W 105th St. [Map](#)

1.3 Mi

1.3 Mi Total



2. Merge onto US-20 W / US-12 W / W 95th St toward I-294-TOLL N. [Map](#)

0.5 Mi

1.8 Mi Total



3. Merge onto I-294 N toward Wisconsin (Portions toll). [Map](#)

9.8 Mi

11.6 Mi Total



4. Merge onto US-34 E / Ogden Ave. [Map](#)

1.0 Mi

12.6 Mi Total



5. Turn left onto Wolf Rd. [Map](#)

Wolf Rd is just past Lawn Ave

If you reach Johnson Ave you've gone a little too far

1.6 Mi

14.2 Mi Total



6. **2400 WOLF RD STE 101A** is on the left. [Map](#)

Your destination is just past Summerdale St

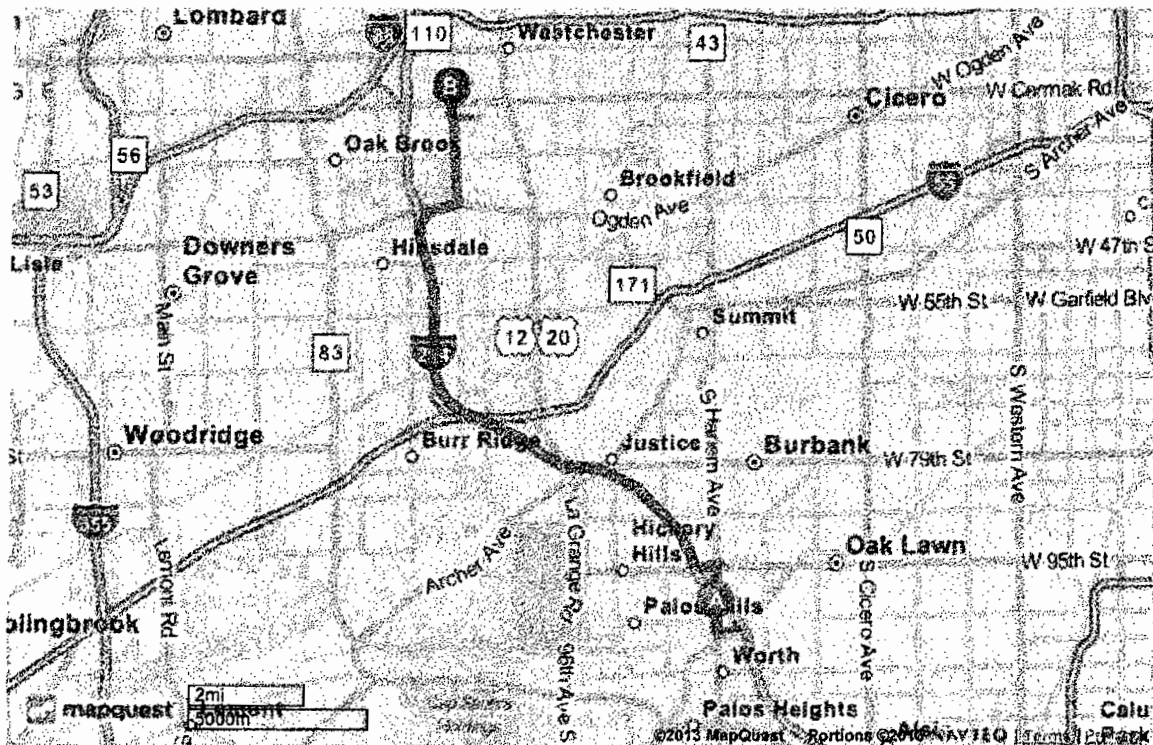
If you reach Westbrook Corporate Ctr you've gone about 0.1 miles too far



2400 Wolf Rd Ste 101a, Westchester, IL 60154-5635

Total Travel Estimate: 14.21 miles - about 21 minutes

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Notes

Fresenius Medical Care of Mokena

Trip to:

8910 W 192nd St

Mokena, IL 60448-8110

13.21 miles / 24 minutes



[10451-10548] S Harlem Ave, Palos Hills, IL 60465



1. Start out going south on S Harlem Ave / IL-43 S toward SouthWest Hwy / IL-7.

10.8 Mi

[Map](#)

10.8 Mi Total



2. Turn right onto W 191st St. [Map](#)

2.0 Mi

T.G.I. Friday's is on the right

12.9 Mi Total

If you reach Oak Park Ave you've gone about 0.2 miles too far



3. Turn left onto S 88th Ave. [Map](#)

0.2 Mi

S 88th Ave is 0.3 miles past 85th Ct

13.1 Mi Total

If you reach Darvin Dr you've gone about 0.4 miles too far



4. Take the 1st right onto W 192nd St. [Map](#)

0.2 Mi

The Breakfast Nook is on the right

13.2 Mi Total

If you reach Clare Ave you've gone about 0.1 miles too far



5. **8910 W 192ND ST** is on the right. [Map](#)

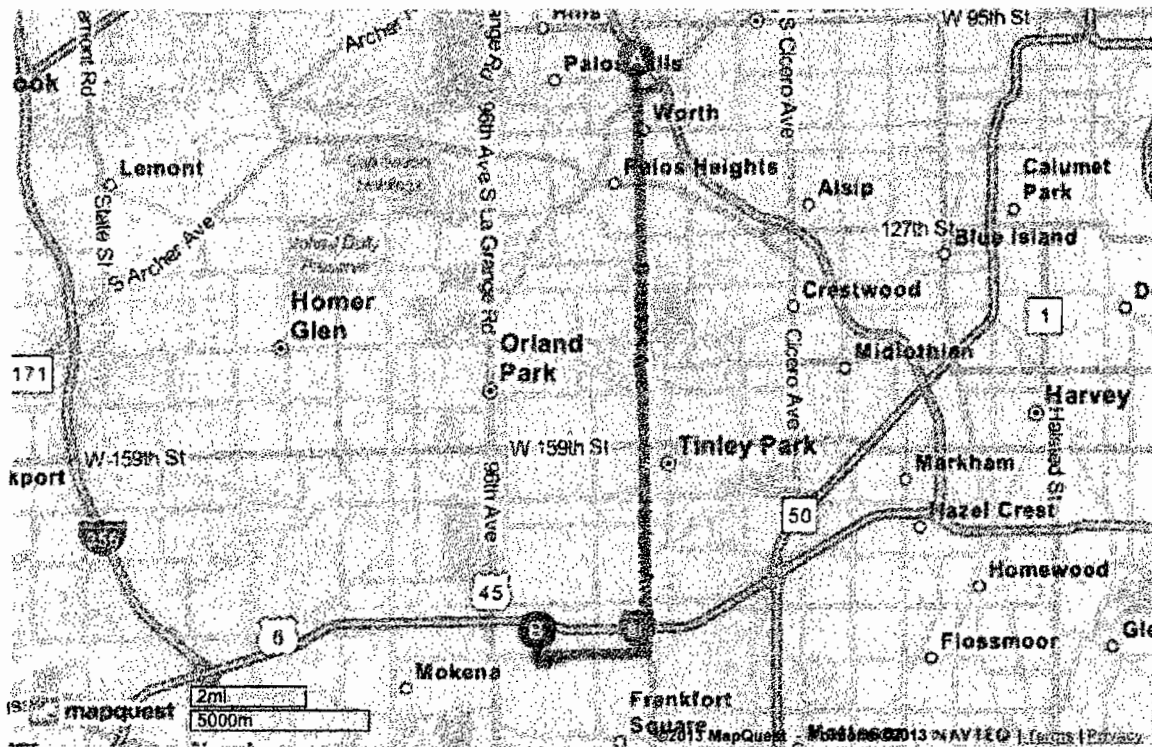
If you reach W 191st St you've gone about 0.4 miles too far



8910 W 192nd St, Mokena, IL 60448-8110

Total Travel Estimate: 13.21 miles - about 24 minutes

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Notes

Palos Park Dialysis

Trip to:

13155 S la Grange Rd

Orland Park, IL 60462-1162

4.99 miles / 10 minutes



[10451-10548] S Harlem Ave, Palos Hills, IL 60465



1. Start out going **south** on **S Harlem Ave / IL-43** toward **SouthWest Hwy**. [Map](#)

0.1 Mi

0.1 Mi Total



7

2. Take the **1st right** onto **SouthWest Hwy / IL-7**. [Map](#)

4.1 Mi

4.3 Mi Total

Brooklyn Pizza is on the corner

If you are on S Harlem Ave and reach W 107th St you've gone a little too far



3. Turn **right** onto **W 131st St**. [Map](#)

0.7 Mi

4.9 Mi Total

W 131st St is 0.6 miles past W 126th St

Murphys Pub is on the corner

If you are on SouthWest Hwy and reach W 135th St you've gone about 0.5 miles too far



45

4. Turn **left** onto **S La Grange Rd / 96th Ave / US-45**. [Map](#)

0.05 Mi

5.0 Mi Total

S La Grange Rd is 0.2 miles past S 94th Ave

It's Greek to Me is on the left

If you reach S Mill Rd you've gone about 0.2 miles too far



5. **13155 S LA GRANGE RD** is on the **left**. [Map](#)

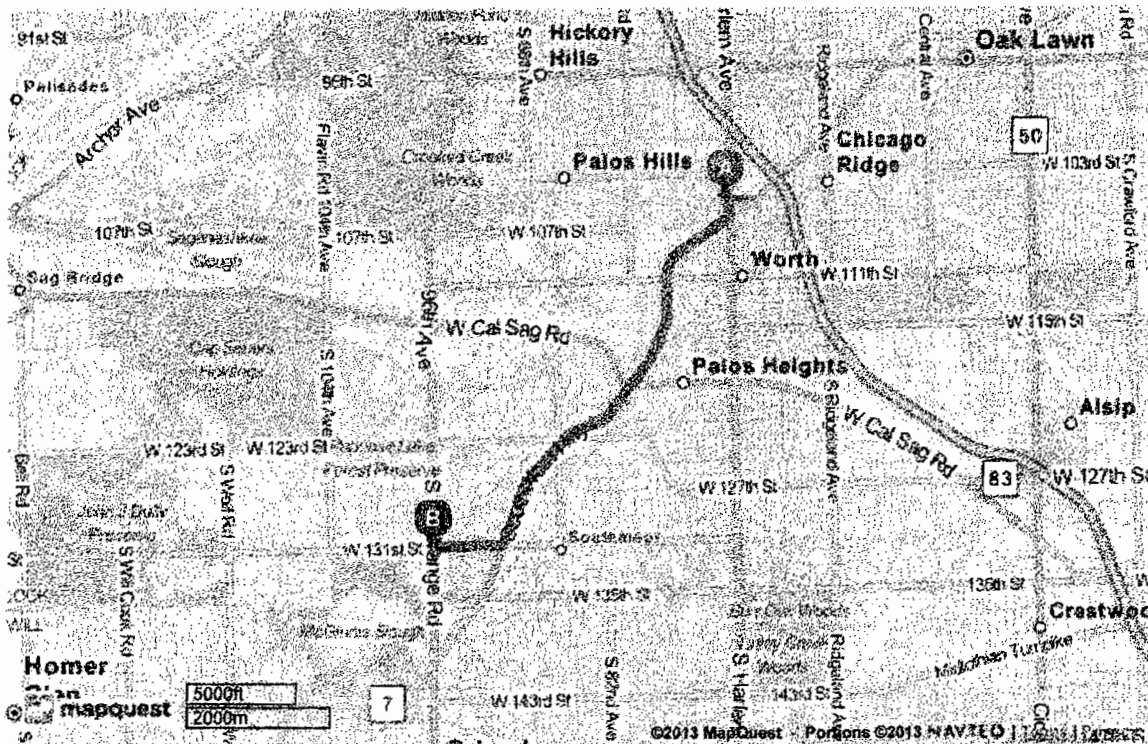
If you reach Southmoor Dr you've gone about 0.1 miles too far



13155 S la Grange Rd, Orland Park, IL 60462-1162

Total Travel Estimate: 4.99 miles - about 10 minutes

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Notes

FMC - Dialysis Center of America - Orland Park

Trip to:

9160 W 159th St

Orland Park, IL 60462-5648

8.89 miles / 17 minutes



[10451-10548] S Harlem Ave, Palos Hills, IL 60465



1. Start out going south on **S Harlem Ave / IL-43** toward **SouthWest Hwy**. [Map](#)

0.1 Mi

0.1 Mi Total



7

2. Take the 1st right onto **SouthWest Hwy / IL-7**. [Map](#)

4.7 Mi

4.8 Mi Total

Brooklyn Pizza is on the corner

If you are on S Harlem Ave and reach W 107th St you've gone a little too far



3. Turn right onto **W 135th St**. [Map](#)

0.5 Mi

5.3 Mi Total

W 135th St is 0.5 miles past W 131st St



45

4. Turn left onto **S La Grange Rd / 96th Ave / US-45**. [Map](#)

3.0 Mi

8.3 Mi Total



6

5. Turn left onto **W 159th St / US-6**. [Map](#)

0.6 Mi

8.9 Mi Total

W 159th St is 0.3 miles past 156th Pl

Fat Sam's Pub is on the right

If you reach 163rd St you've gone about 0.5 miles too far



6. **9160 W 159TH ST** is on the left. [Map](#)

Your destination is 0.3 miles past S 94th Ave

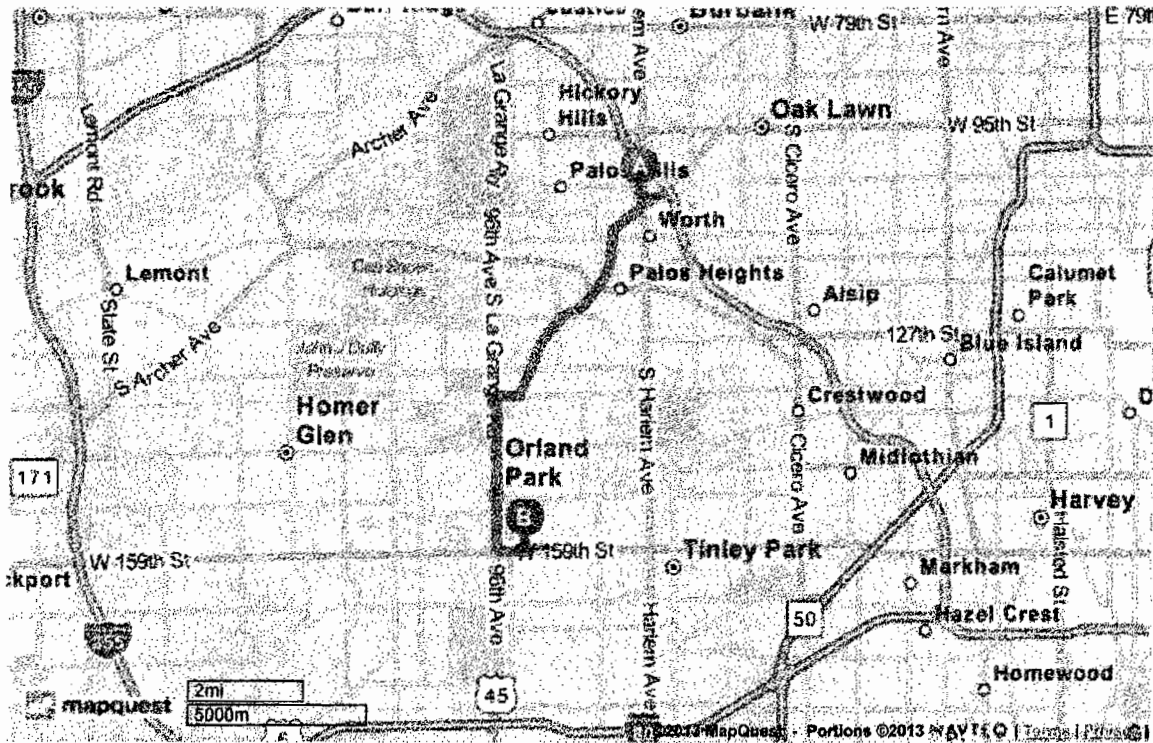
If you reach Parkhill Dr you've gone a little too far



9160 W 159th St, Orland Park, IL 60462-5648

Total Travel Estimate: 8.89 miles - about 17 minutes

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Notes

Olympia Fields Dialysis Center

Trip to:

4557 Lincoln Hwy Ste B

Matteson, IL 60443-2385

16.74 miles / 29 minutes



[10451-10548] S Harlem Ave, Palos Hills, IL 60465



1. Start out going south on **S Harlem Ave / IL-43 S** toward **SouthWest Hwy / IL-7**.
[Map](#)

13.5 Mi

13.5 Mi Total



2. Turn left onto **211th St / Lincoln Hwy / W Lincoln Hwy / US-30 E**. Continue to follow **211th St / Lincoln Hwy / US-30 E**. [Map](#)
211th St is 0.4 miles past W Hickory Creek Dr
If you reach Georgetown Commons you've gone about 0.3 miles too far

3.3 Mi

16.7 Mi Total



3. **4557 LINCOLN HWY STE B** is on the right. [Map](#)

Your destination is just past Lindenwood Dr

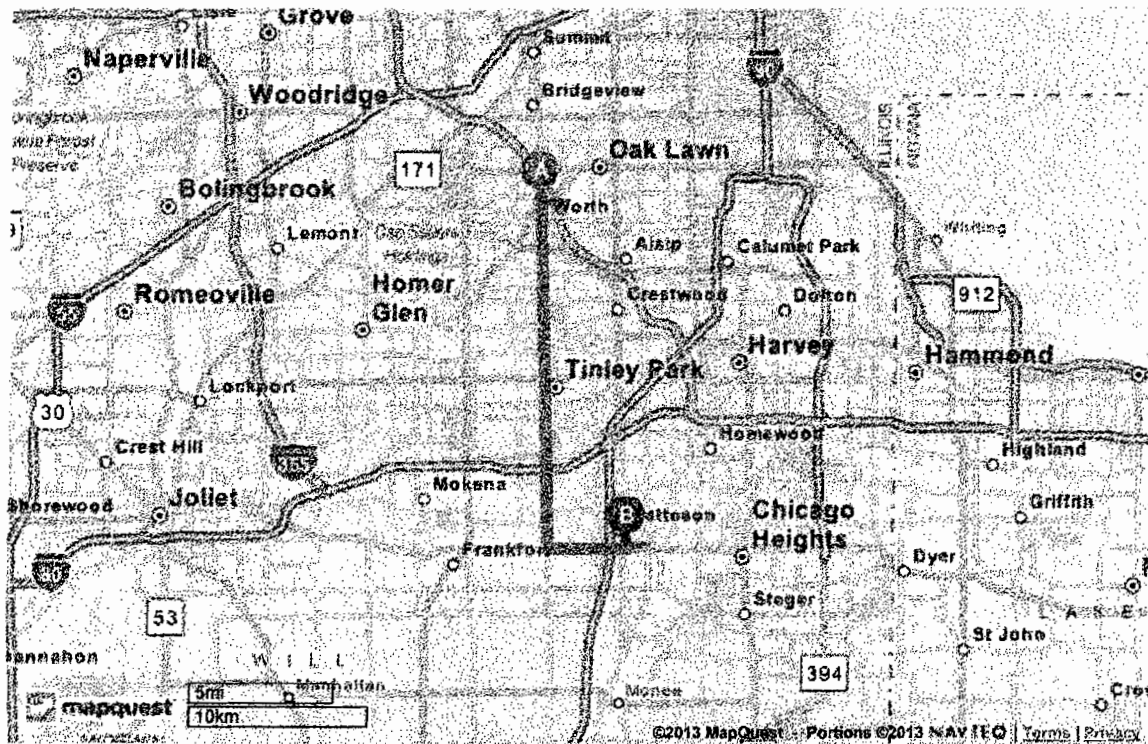
If you reach Kostner Ave you've gone about 0.2 miles too far



4557 Lincoln Hwy Ste B, Matteson, IL 60443-2385

Total Travel Estimate: 16.74 miles - about 29 minutes

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Notes

Direct Dialysis - Crestwood Care Centre

Trip to:

14255 Cicero Ave

Crestwood, IL 60445-2154

6.56 miles / 14 minutes



[10451-10548] S Harlem Ave, Palos Hills, IL 60465



1. Start out going south on S Harlem Ave / IL-43 toward SouthWest Hwy / IL-7.

1.7 Mi

[Map](#)

1.7 Mi Total



83

2. Turn left onto W College Dr / IL-83. Continue to follow IL-83. [Map](#)

2.5 Mi

IL-83 is 0.3 miles past W 116th St

Sherwin-Williams Paint Store is on the corner

If you reach W 119th Pl you've gone a little too far

4.2 Mi Total



3. Stay straight to go onto Cal Sag Rd. [Map](#)

0.9 Mi

5.2 Mi Total



50

4. Turn right onto IL-50 / Cicero Ave / IL-83. [Map](#)

1.4 Mi

IL-50 is 0.3 miles past Rivercrest Dr

Beds Beds Beds is on the corner

If you reach Kolmar Ave you've gone about 0.5 miles too far

6.6 Mi Total



5. **14255 CICERO AVE** is on the left. [Map](#)

Your destination is just past 142nd St

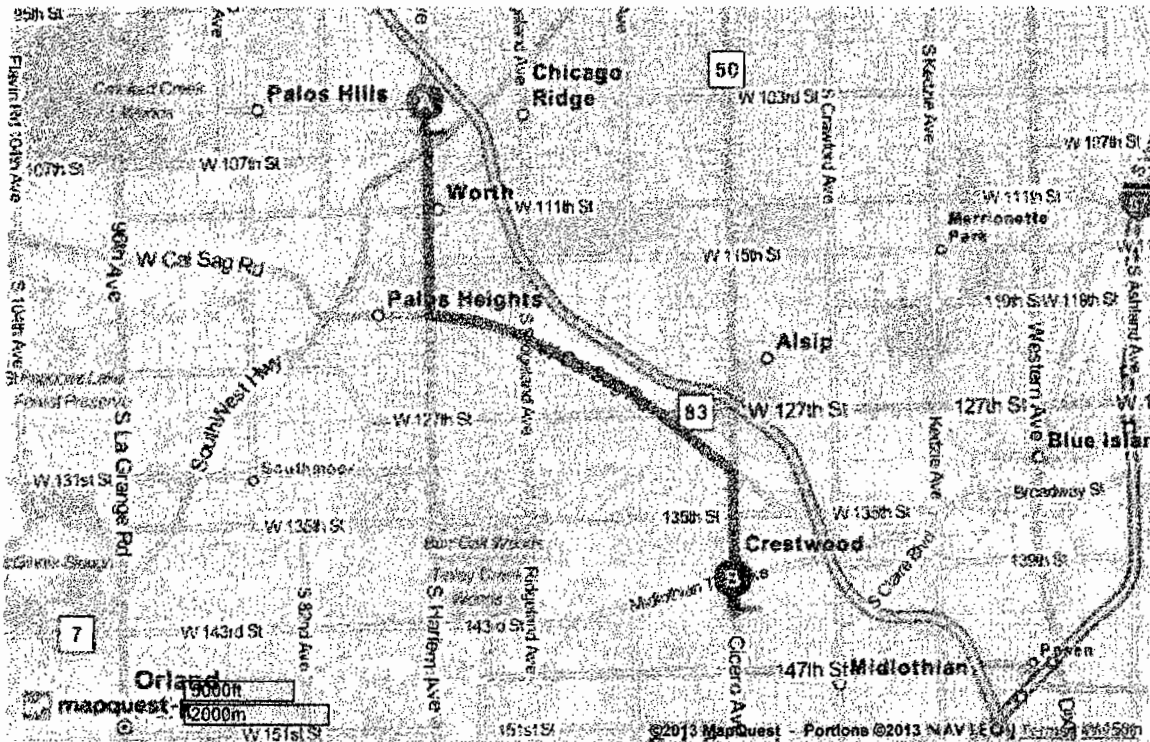
If you reach 143rd St you've gone a little too far



14255 Cicero Ave, Crestwood, IL 60445-2154

Total Travel Estimate: 6.56 miles - about 14 minutes

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Notes

FMC - Dialysis Center of America - Crestwood

Trip to:

4861 Cal Sag Rd # 73

Crestwood, IL 60445-4415

5.08 miles / 10 minutes



[10451-10548] S Harlem Ave, Palos Hills, IL 60465



1. Start out going **south** on **S Harlem Ave / IL-43** toward **SouthWest Hwy / IL-7**.

[Map](#)

1.7 Mi

1.7 Mi Total



2. Turn **left** onto **W College Dr / IL-83**. Continue to follow **IL-83**. [Map](#)

IL-83 is 0.3 miles past W 116th St

Sherwin-Williams Paint Store is on the corner

If you reach W 119th Pl you've gone a little too far

2.5 Mi

4.2 Mi Total



3. Stay **straight** to go onto **Cal Sag Rd**. [Map](#)

0.8 Mi

5.1 Mi Total



4. **4861 CAL SAG RD # 73** is on the **right**. [Map](#)

Your destination is 0.2 miles past Rivercrest Dr

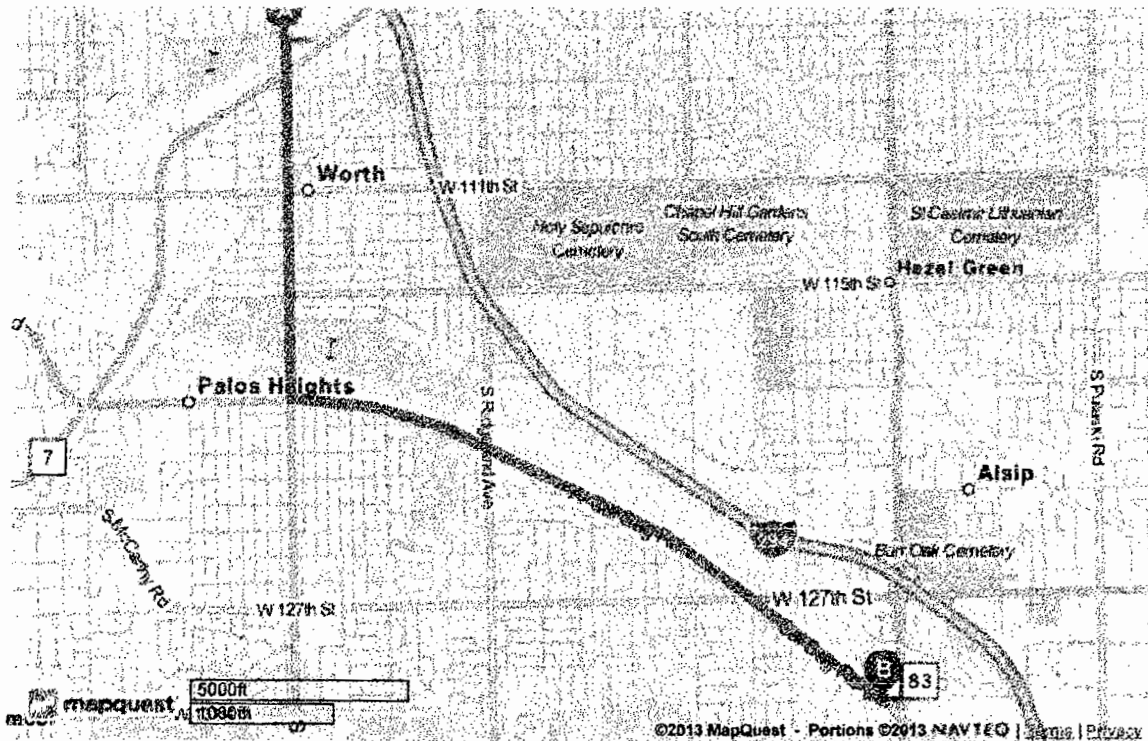
If you reach IL-50 you've gone about 0.1 miles too far



4861 Cal Sag Rd # 73, Crestwood, IL 60445-4415

Total Travel Estimate: 5.08 miles - about 10 minutes

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Notes

FMC - Alsip Dialysis Center

Trip to:

12250 S Cicero Ave Ste 105

Alsip, IL 60803-2946

5.58 miles / 12 minutes



[10451-10548] S Harlem Ave, Palos Hills, IL 60465



1. Start out going **south** on **S Harlem Ave / IL-43** toward **SouthWest Hwy / IL-7**.
[Map](#)

1.7 Mi

1.7 Mi Total



83

2. Turn **left** onto **W College Dr / IL-83**. Continue to follow **IL-83**. [Map](#)
*IL-83 is 0.3 miles past W 116th St
Sherwin-Williams Paint Store is on the corner
If you reach W 119th Pl you've gone a little too far*

2.5 Mi

4.2 Mi Total



83

3. Turn **slight left** onto **W 127th St / IL-83**. [Map](#)

*W 127th St is 0.3 miles past S Central Ave
SPEEDWAY #7750 is on the corner*

0.7 Mi

5.0 Mi Total



50

4. Turn **left** onto **IL-50 N / S Cicero Ave**. [Map](#)

IL-50 N is 0.1 miles past S Laporte Ave

If you reach S Kostner Ave you've gone about 0.4 miles too far

0.6 Mi

5.6 Mi Total



5. **12250 S CICERO AVE STE 105** is on the **left**. [Map](#)

Your destination is just past W 123rd St

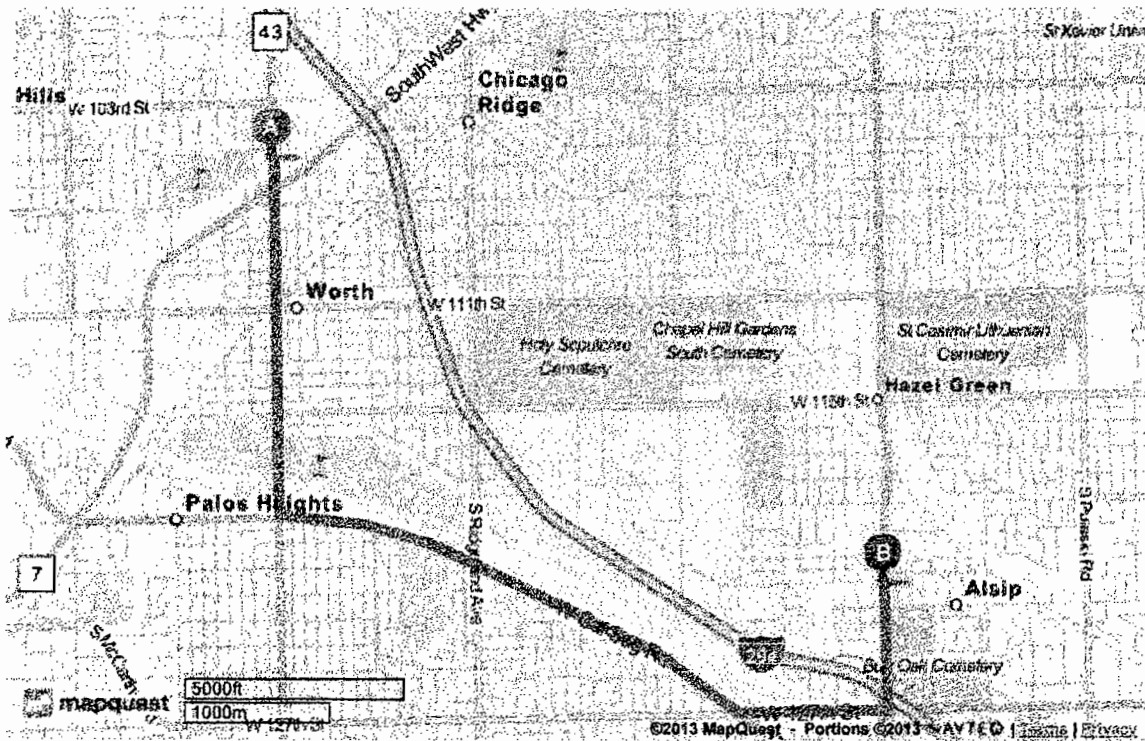
If you reach W 122nd St you've gone a little too far



12250 S Cicero Ave Ste 105, Alsip, IL 60803-2946

Total Travel Estimate: 5.58 miles - about 12 minutes

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Notes

Stoney Creek Dialysis

Trip to:

9115 S Cicero Ave

Oak Lawn, IL 60453-1895

4.03 miles / 10 minutes



[10451-10548] S Harlem Ave, Palos Hills, IL 60465



1. Start out going south on S Harlem Ave / IL-43 toward SouthWest Hwy / IL-7.

0.1 Mi

[Map](#)

0.1 Mi Total



2. Take the 1st left onto SouthWest Hwy. [Map](#)

3.7 Mi

Brooklyn Pizza is on the corner

3.8 Mi Total

If you reach W 107th St you've gone a little too far



3. Turn left onto S Cicero Ave / IL-50. [Map](#)

0.2 Mi

S Cicero Ave is just past S 48th Ct

4.0 Mi Total

Boston Market is on the corner

If you reach S Keating Ave you've gone a little too far



4. 9115 S CICERO AVE is on the right. [Map](#)

Your destination is just past W 91st Pl

If you reach W 91st St you've gone a little too far



9115 S Cicero Ave, Oak Lawn, IL 60453-1895



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Notes

Fresenius Medical Care - Midway

Trip to:

6201 W 63rd St

Chicago, IL 60638-5009

6.71 miles / 15 minutes



[10451-10548] S Harlem Ave, Palos Hills, IL 60465



1. Start out going north on **S Harlem Ave / IL-43** toward **W 105th St**. [Map](#)

5.5 Mi

5.5 Mi Total



2. Turn **right** onto **W 63rd St**. [Map](#)

1.3 Mi

W 63rd St is just past W 63rd Pl

6.7 Mi Total

SHELL is on the corner

If you reach W 62nd St you've gone about 0.1 miles too far



3. **6201 W 63RD ST** is on the **right**. [Map](#)

Your destination is just past S Merrimac Ave

If you reach S Melvina Ave you've gone a little too far



6201 W 63rd St, Chicago, IL 60638-5009

Total Travel Estimate: 6.71 miles - about 15 minutes

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Notes

FMC Dialysis Services - Burbank

Trip to:

4811 W 77th St

Burbank, IL 60459-1586

6.16 miles / 14 minutes



[10451-10548] S Harlem Ave, Palos Hills, IL 60465



1. Start out going north on S Harlem Ave / IL-43 toward W 105th St. [Map](#)

2.3 Mi

2.3 Mi Total



2. Turn right onto W 87th St. [Map](#)

1.0 Mi

3.3 Mi Total

W 87th St is just past W 87th Pl

Circle K is on the corner

If you are on S Harlem Ave and reach W 86th St you've gone about 0.1 miles too far



3. Turn slight left onto State Rd. [Map](#)

1.5 Mi

4.8 Mi Total

State Rd is just past Nagle Ave

Les Brothers Restaurant is on the corner

If you are on W 87th St and reach Mobile Ave you've gone a little too far



4. Turn slight right onto W 79th St. [Map](#)

0.8 Mi

5.7 Mi Total

W 79th St is just past Linder Ave

Best Taste Deli Inc is on the right

If you are on State Rd and reach Lotus Ave you've gone a little too far



50

5. Turn left onto S Cicero Ave / IL-50. [Map](#)

0.4 Mi

6.0 Mi Total

S Cicero Ave is just past La Crosse Ave

Dunkin Donuts is on the corner

If you reach S Keating Ave you've gone a little too far



6. Turn left onto W 76th St / W 77th St. [Map](#)

0.1 Mi

6.1 Mi Total

W 76th St is 0.2 miles past W 78th St

Olive Garden Italian Restaurant is on the left

If you reach S State Rd you've gone about 0.3 miles too far



7. Turn left. [Map](#)

0.02 Mi

6.2 Mi Total

Popeyes Chicken & Biscuits is on the left



8. Take the 1st right onto W 77th St. [Map](#)

Popeyes Chicken & Biscuits is on the corner



9. **4811 W 77TH ST** is on the left. [Map](#)

If you reach the end of W 77th St you've gone a little too far



4811 W 77th St, Burbank, IL 60459-1586



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Notes

RCG-Scottsdale

Trip to:

4651 W 79th St

Chicago, IL 60652-1186

5.84 miles / 13 minutes



[10451-10548] S Harlem Ave, Palos Hills, IL 60465



1. Start out going north on **S Harlem Ave / IL-43** toward **W 105th St**. [Map](#)

2.3 Mi

2.3 Mi Total



2. Turn **right** onto **W 87th St**. [Map](#)

1.0 Mi

3.3 Mi Total

W 87th St is just past W 87th Pl

Circle K is on the corner

If you are on S Harlem Ave and reach W 86th St you've gone about 0.1 miles too far



3. Turn **slight left** onto **State Rd**. [Map](#)

1.5 Mi

4.8 Mi Total

State Rd is just past Nagle Ave

Les Brothers Restaurant is on the corner

If you are on W 87th St and reach Mobile Ave you've gone a little too far



4. Turn **slight right** onto **W 79th St**. [Map](#)

1.0 Mi

5.8 Mi Total

W 79th St is just past Linder Ave

Best Taste Deli Inc is on the right

If you are on State Rd and reach Lotus Ave you've gone a little too far



5. **4651 W 79TH ST** is on the **right**. [Map](#)

Your destination is just past S Kilpatrick Ave

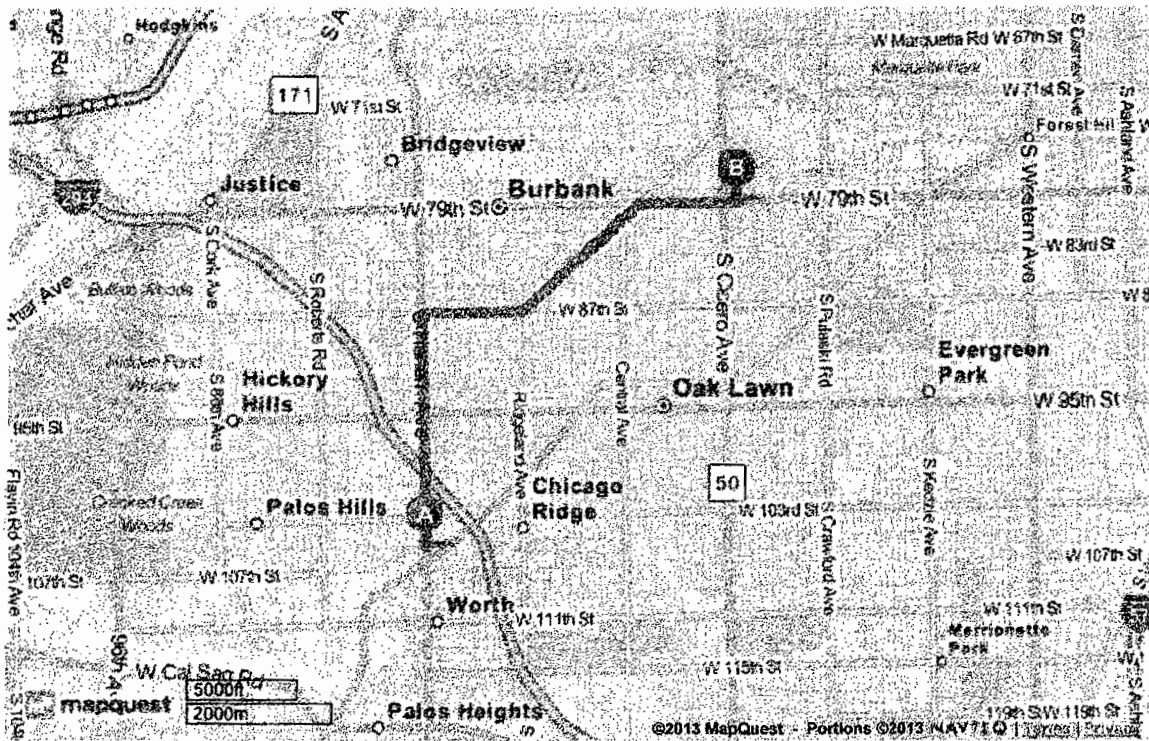
If you reach S Knox Ave you've gone a little too far



4651 W 79th St, Chicago, IL 60652-1186

Total Travel Estimate: 5.84 miles - about 13 minutes

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Notes

West Lawn Dialysis

Trip to:

7000 S Pulaski Rd

Chicago, IL 60629-5842

7.76 miles / 18 minutes



[10451-10548] S Harlem Ave, Palos Hills, IL 60465



1. Start out going **north** on **S Harlem Ave / IL-43** toward **W 105th St.** [Map](#)

2.3 Mi

2.3 Mi Total



2. Turn **right** onto **W 87th St.** [Map](#)

1.0 Mi

3.3 Mi Total

W 87th St is just past W 87th Pl

Circle K is on the corner

If you are on S Harlem Ave and reach W 86th St you've gone about 0.1 miles too far



3. Turn **slight left** onto **State Rd.** [Map](#)

1.5 Mi

4.8 Mi Total

State Rd is just past Nagle Ave

Les Brothers Restaurant is on the corner

If you are on W 87th St and reach Mobile Ave you've gone a little too far



4. Turn **slight right** onto **W 79th St.** [Map](#)

1.8 Mi

6.7 Mi Total

W 79th St is just past Linder Ave

Best Taste Deli Inc is on the right

If you are on State Rd and reach Lotus Ave you've gone a little too far



5. Turn **left** onto **S Pulaski Rd.** [Map](#)

1.1 Mi

7.8 Mi Total

S Pulaski Rd is just past S Komensky Ave

1326 4010 W 79 is on the corner

If you reach S Springfield Ave you've gone a little too far



6. **7000 S PULASKI RD** is on the **left.** [Map](#)

Your destination is just past W 70th Pl

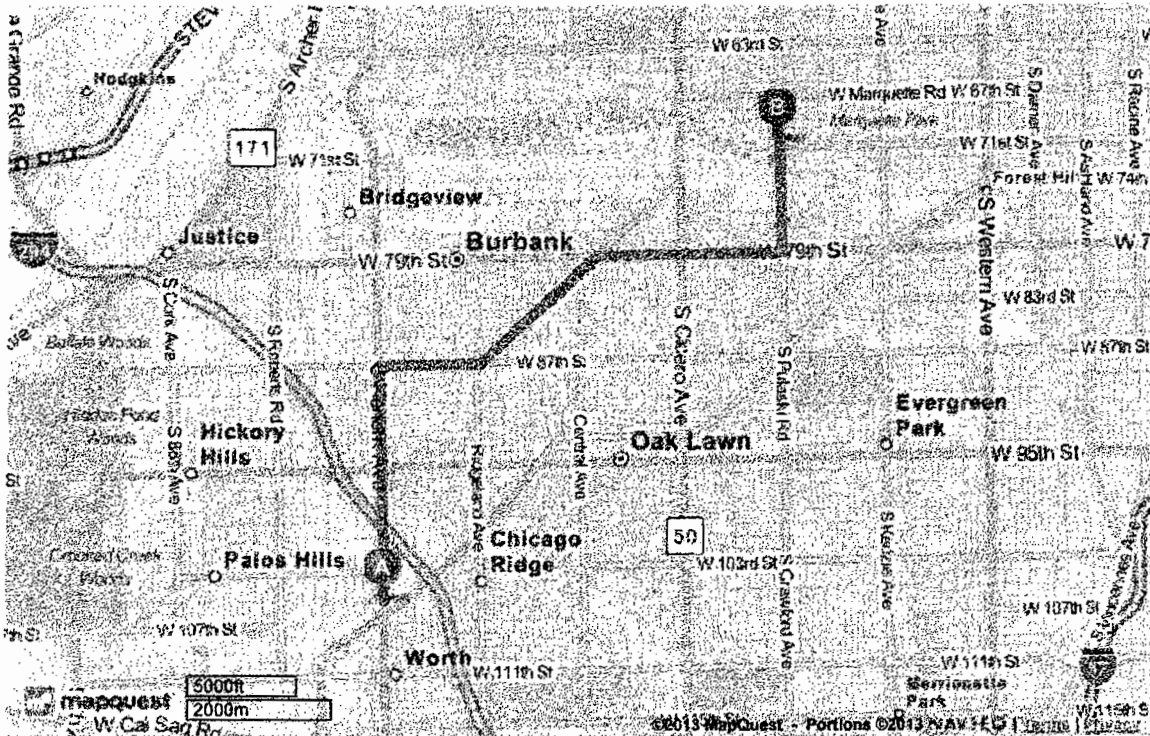
If you reach W 70th St you've gone a little too far



7000 S Pulaski Rd, Chicago, IL 60629-5842

Total Travel Estimate: 7.76 miles - about 18 minutes

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Notes

FMC - Dialysis Center of America - Olympia Fields

Trip to:

2609 Lincoln Hwy

Olympia Fields, IL 60461-1801

19.21 miles / 34 minutes



[10451-10548] S Harlem Ave, Palos Hills, IL 60465



1. Start out going south on S Harlem Ave / IL-43 S toward SouthWest Hwy / IL-7.
[Map](#)

13.5 Mi

13.5 Mi Total



2. Turn left onto 211th St / Lincoln Hwy / W Lincoln Hwy / US-30 E. Continue to follow Lincoln Hwy / US-30 E. [Map](#)

5.8 Mi

19.2 Mi Total

Lincoln Hwy is 0.4 miles past W Hickory Creek Dr

If you reach Georgetown Commons you've gone about 0.3 miles too far



3. **2609 LINCOLN HWY** is on the left. [Map](#)

Your destination is 0.4 miles past Orchard Dr

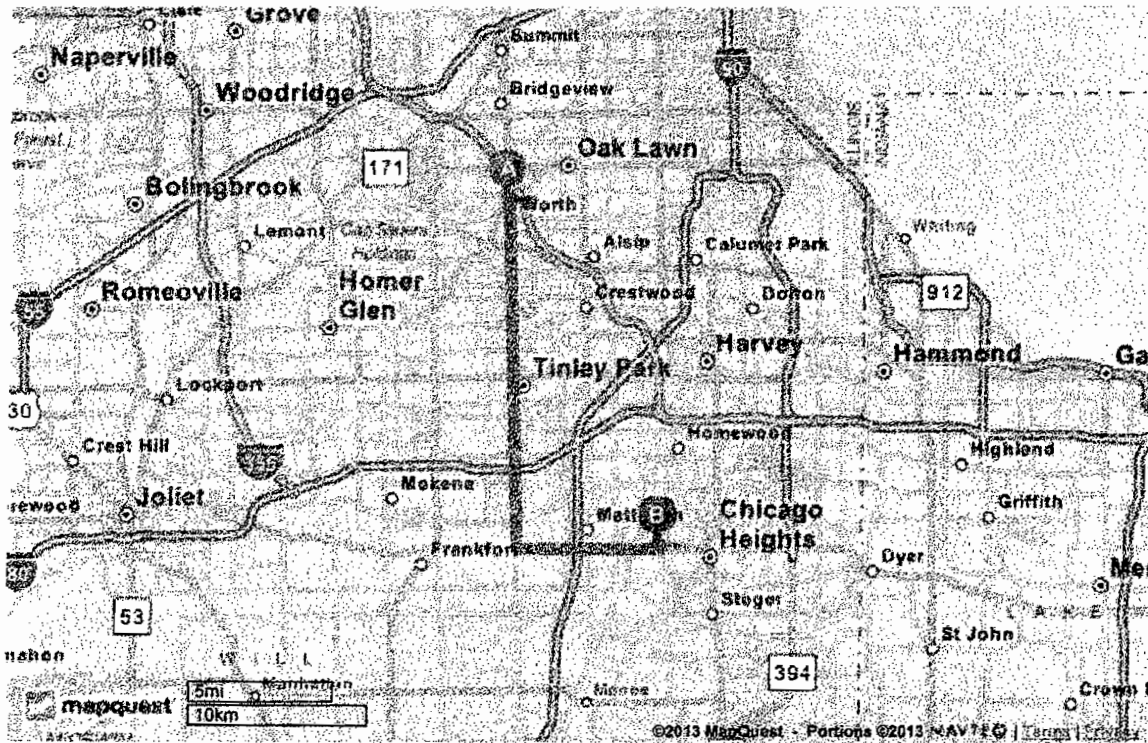
If you reach Brookwood Dr you've gone a little too far



2609 Lincoln Hwy, Olympia Fields, IL 60461-1801

Total Travel Estimate: 19.21 miles - about 34 minutes

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Notes

Hazel Crest Renal Center

Trip to:

3470 W 183rd St

Hazel Crest, IL 60429-2428

13.52 miles / 27 minutes



[10451-10548] S Harlem Ave, Palos Hills, IL 60465



1. Start out going **south** on **S Harlem Ave / IL-43** toward **SouthWest Hwy / IL-7**.

1.7 Mi

[Map](#)

1.7 Mi Total



83

2. Turn **left** onto **W College Dr / IL-83**. Continue to follow **IL-83**. [Map](#)

2.5 Mi

IL-83 is 0.3 miles past W 116th St

4.2 Mi Total

Sherwin-Williams Paint Store is on the corner

If you reach W 119th Pl you've gone a little too far



3. Stay **straight** to go onto **Cal Sag Rd**. [Map](#)

0.9 Mi

5.2 Mi Total



50

4. Turn **right** onto **IL-50 / Cicero Ave / IL-83**. Continue to follow **IL-50 / Cicero Ave**.

5.7 Mi

[Map](#)

10.8 Mi Total

IL-50 is 0.3 miles past Rivercrest Dr

Beds Beds Beds is on the corner

If you reach Kolmar Ave you've gone about 0.5 miles too far



5. Turn **left** onto **175th St**. [Map](#)

1.0 Mi

175th St is 0.3 miles past 173rd St

11.9 Mi Total

If you reach Wilshire Blvd you've gone a little too far



6. Turn **right** onto **Pulaski Rd / Crawford Ave**. [Map](#)

1.0 Mi

Pulaski Rd is just past Eastgate Dr

12.9 Mi Total

Docks Fish is on the corner

If you reach Winston Dr you've gone a little too far



7. Turn **left** onto **183rd St**. [Map](#)

0.7 Mi

183rd St is 0.1 miles past Fairway Ter

13.5 Mi Total

Walgreens is on the corner

If you reach 40th Ct you've gone a little too far



8. **3470 W 183RD ST** is on the left. [Map](#)

Your destination is just past Village Dr

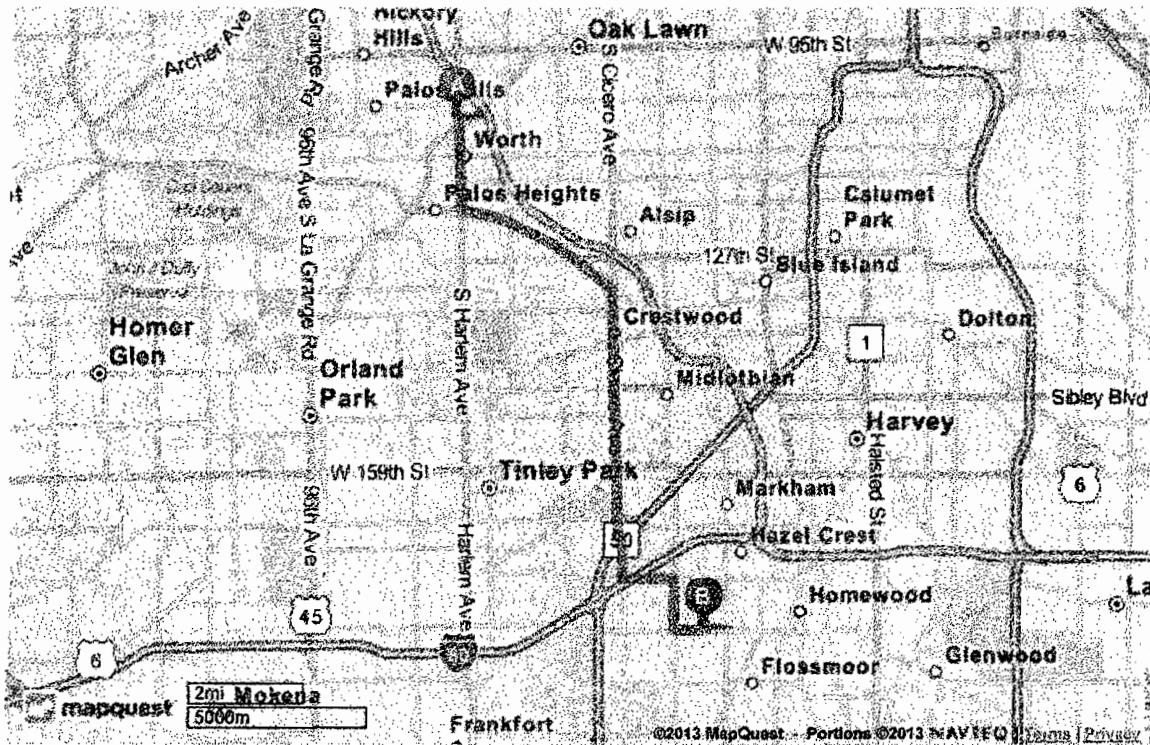
If you reach Grenoble Dr you've gone a little too far



3470 W 183rd St, Hazel Crest, IL 60429-2428

Total Travel Estimate: 13.52 miles - about 27 minutes

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Notes

Fresenius Medical Care Hazel Crest

Trip to:

Hazel Crest, IL 60429

13.93 miles / 24 minutes

**[10451-10548] S Harlem Ave, Palos Hills, IL 60465**

1. Start out going south on S Harlem Ave / IL-43 toward SouthWest Hwy / IL-7.

1.7 Mi[Map](#)

1.7 Mi Total

2. Turn left onto W College Dr / IL-83. Continue to follow IL-83. [Map](#)**2.5 Mi**

IL-83 is 0.3 miles past W 116th St

Sherwin-Williams Paint Store is on the corner

If you reach W 119th Pl you've gone a little too far

4.2 Mi Total

3. Turn slight left onto W 127th St / IL-83. Continue to follow W 127th St. [Map](#)**1.0 Mi**

W 127th St is 0.3 miles past S Central Ave

SPEEDWAY #7750 is on the corner

If you are on Cal Sag Rd and reach W Playfield Dr you've gone a little too far

5.2 Mi Total

4. Merge onto I-294 S toward Indiana (Portions toll). [Map](#)**6.8 Mi**

If you reach S Kostner Ave you've gone about 0.2 miles too far

12.1 Mi Total

5. Merge onto I-80 E toward Dixie Hwy. [Map](#)**0.6 Mi**

12.7 Mi Total

6. Take the Dixie Hwy exit. [Map](#)**0.2 Mi**

12.9 Mi Total

7. Turn right onto Dixie Hwy. [Map](#)**0.4 Mi**

13.2 Mi Total

8. Take the 1st right onto 175th St. [Map](#)**0.6 Mi**

175th St is 0.1 miles past Cheker Sq

MOBIL is on the right

If you reach Spruce Rd you've gone a little too far

13.8 Mi Total

9. Turn right onto Jovanna Dr. [Map](#)**0.1 Mi**

Jovanna Dr is just past Western Ave

If you reach Palmer Blvd you've gone a little too far

13.9 Mi Total

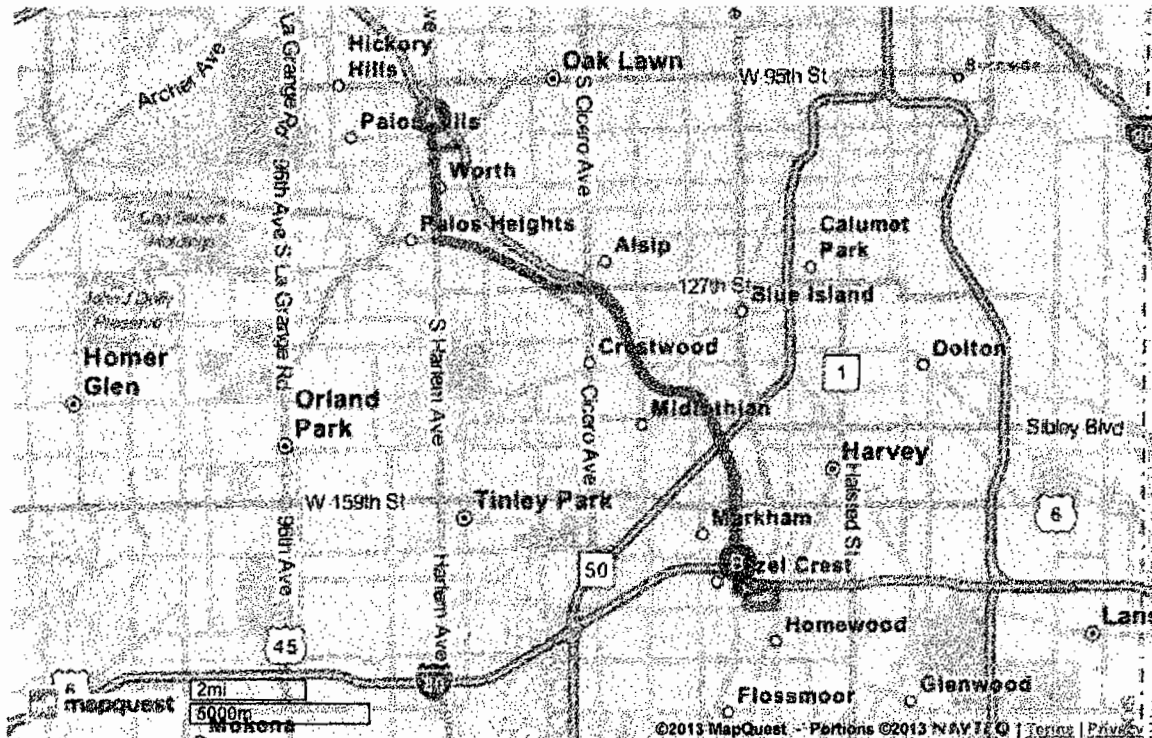
10. Welcome to HAZEL CREST, IL 60429. [Map](#)

Your destination is at the end of Jovanna Dr

**Hazel Crest, IL 60429**

Total Travel Estimate: 13.93 miles - about 24 minutes

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Notes

Chicago Heights Dialysis

Trip to:

177 W Joe Orr Rd

Chicago Heights, IL 60411-1733

18.89 miles / 32 minutes



[10451-10548] S Harlem Ave, Palos Hills, IL 60465



1. Start out going **south** on **S Harlem Ave / IL-43** toward **SouthWest Hwy / IL-7**.

[Map](#)

1.7 Mi

1.7 Mi Total



83

2. Turn **left** onto **W College Dr / IL-83**. Continue to follow **IL-83**. [Map](#)

IL-83 is 0.3 miles past W 116th St

Sherwin-Williams Paint Store is on the corner

If you reach W 119th Pl you've gone a little too far

2.5 Mi

4.2 Mi Total



3. Turn **slight left** onto **W 127th St / IL-83**. Continue to follow **W 127th St**. [Map](#)

W 127th St is 0.3 miles past S Central Ave

SPEEDWAY #7750 is on the corner

If you are on Cal Sag Rd and reach W Playfield Dr you've gone a little too far

1.0 Mi

5.2 Mi Total



294

4. Merge onto **I-294 S** toward **Indiana** (Portions toll). [Map](#)

If you reach S Kostner Ave you've gone about 0.2 miles too far

8.6 Mi

13.8 Mi Total



1

5. Merge onto **IL-1 S**. [Map](#)

4.4 Mi

18.2 Mi Total



6. Turn **right** onto **E Joe Orr Rd**. [Map](#)

E Joe Orr Rd is 0.1 miles past Eastgate Ave

Brown's Chicken & Pasta is on the corner

If you reach Southgate Ave you've gone about 0.1 miles too far

0.7 Mi

18.9 Mi Total



7. **177 W JOE ORR RD** is on the **right**. [Map](#)

Your destination is 0.2 miles past Chicago Rd

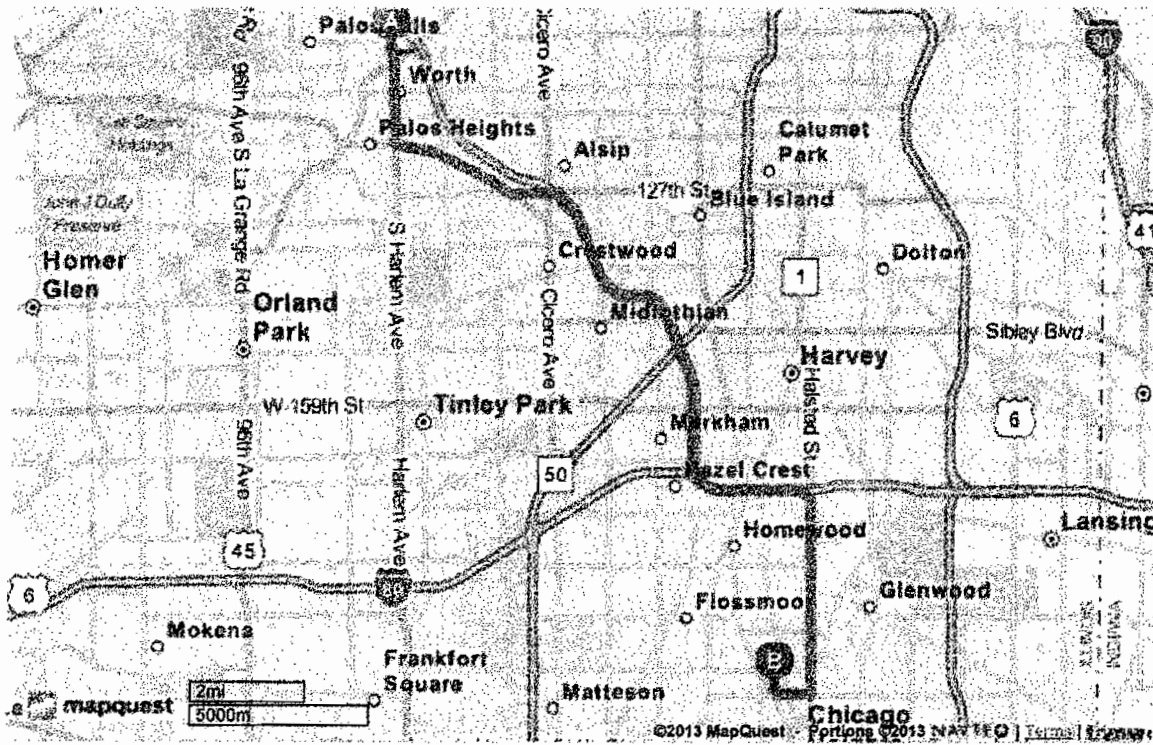
If you reach Dixie Hwy you've gone a little too far



177 W Joe Orr Rd, Chicago Heights, IL 60411-1733

Total Travel Estimate: 18.89 miles - about 32 minutes

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Notes

Markham Renal Center

Trip to:

3053-3055 W 159th St

Markham, IL 60428-4003

11.11 miles / 20 minutes



[10451-10548] S Harlem Ave, Palos Hills, IL 60465



1. Start out going **south** on **S Harlem Ave / IL-43** toward **SouthWest Hwy / IL-7**.

1.7 Mi

[Map](#)

1.7 Mi Total



2. Turn **left** onto **W College Dr / IL-83**. Continue to follow **IL-83**. [Map](#)

2.5 Mi

IL-83 is 0.3 miles past W 116th St

4.2 Mi Total

Sherwin-Williams Paint Store is on the corner

If you reach W 119th Pl you've gone a little too far



3. Turn **slight left** onto **W 127th St / IL-83**. Continue to follow **W 127th St**. [Map](#)

1.0 Mi

W 127th St is 0.3 miles past S Central Ave

5.2 Mi Total

SPEEDWAY #7750 is on the corner

If you are on Cal Sag Rd and reach W Playfield Dr you've gone a little too far



4. Merge onto **I-294 S** toward **Indiana** (Portions toll). [Map](#)

5.0 Mi

If you reach S Kostner Ave you've gone about 0.2 miles too far

10.2 Mi Total



5. Merge onto **W 159th St / US-6 W**. [Map](#)

0.9 Mi

11.1 Mi Total



6. **3053-3055 W 159TH ST**. [Map](#)

Your destination is just past Whipple Ave

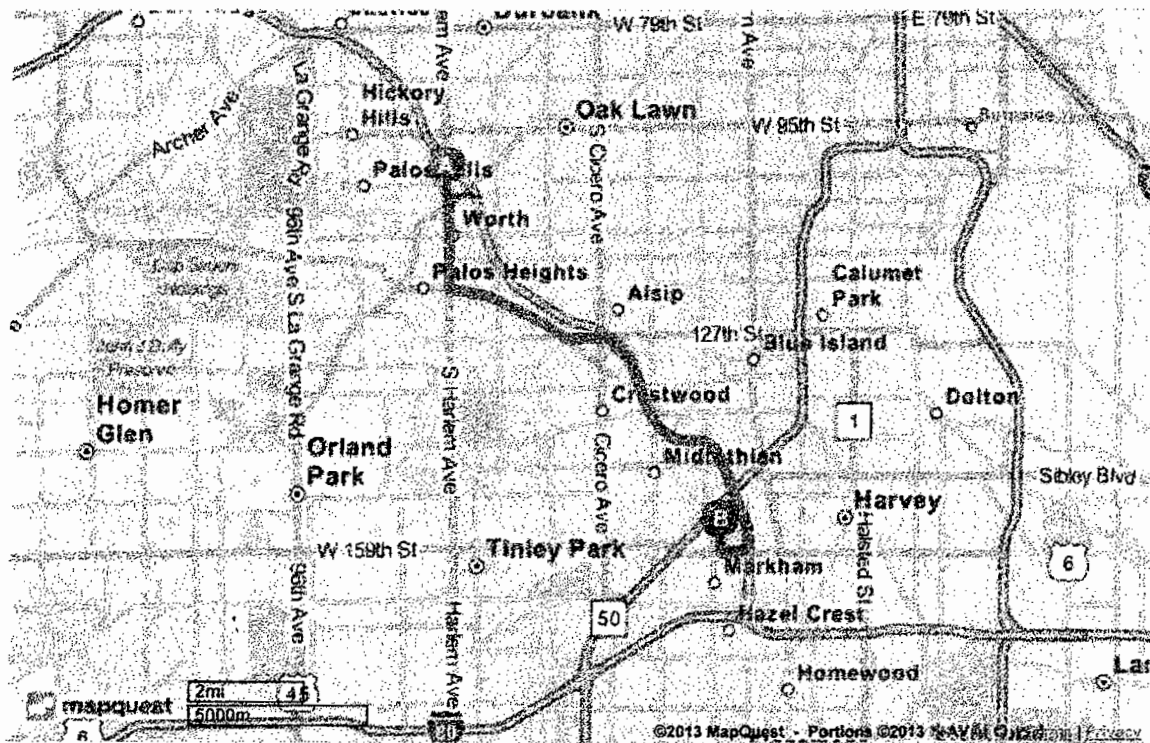
If you reach Albany Ave you've gone a little too far



3053-3055 W 159th St, Markham, IL 60428-4003

Total Travel Estimate: 11.11 miles - about 20 minutes

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Notes

FMC - Blue Island Dialysis Ctr

Trip to:

12200 Western Ave

Blue Island, IL 60406-1398

8.62 miles / 19 minutes



[10451-10548] S Harlem Ave, Palos Hills, IL 60465



1. Start out going **south** on **S Harlem Ave / IL-43** toward **SouthWest Hwy / IL-7**.

[Map](#)

1.7 Mi

1.7 Mi Total



83

2. Turn **left** onto **W College Dr / IL-83**. Continue to follow **IL-83**. [Map](#)

IL-83 is 0.3 miles past W 116th St

Sherwin-Williams Paint Store is on the corner

If you reach W 119th Pl you've gone a little too far

2.5 Mi

4.2 Mi Total



3. Turn **slight left** onto **W 127th St / IL-83**. Continue to follow **W 127th St**. [Map](#)

W 127th St is 0.3 miles past S Central Ave

SPEEDWAY #7750 is on the corner

If you are on Cal Sag Rd and reach W Playfield Dr you've gone a little too far

3.8 Mi

8.0 Mi Total



4. Turn **left** onto **Western Ave**. [Map](#)

Western Ave is just past Artesian Ave

Beggars Pizza is on the left

If you reach Vincennes Rd you've gone about 0.1 miles too far

0.6 Mi

8.6 Mi Total



5. **12200 WESTERN AVE** is on the left. [Map](#)

Your destination is 0.1 miles past 123rd St

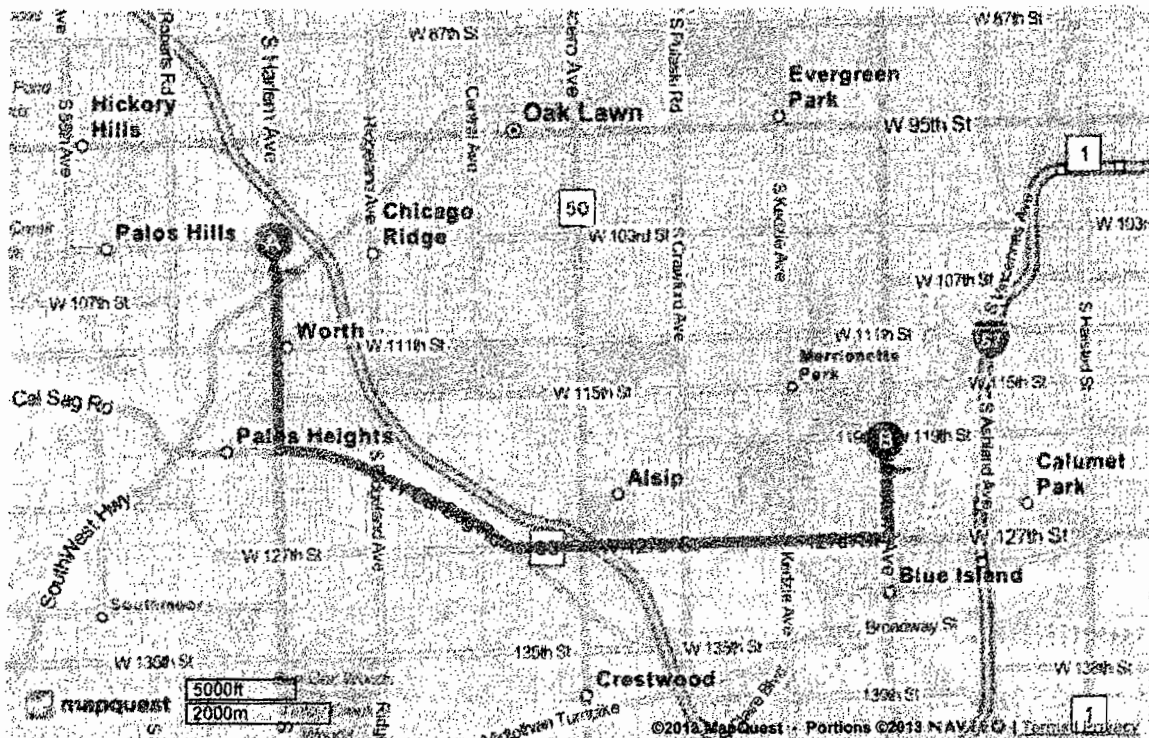
If you reach 122nd St you've gone a little too far



12200 Western Ave, Blue Island, IL 60406-1398

Total Travel Estimate: 8.62 miles - about 19 minutes

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Notes

Community Dialysis of Harvey

Trip to:

16641 Halsted St Ste 1

Harvey, IL 60426-6174

15.24 miles / 25 minutes

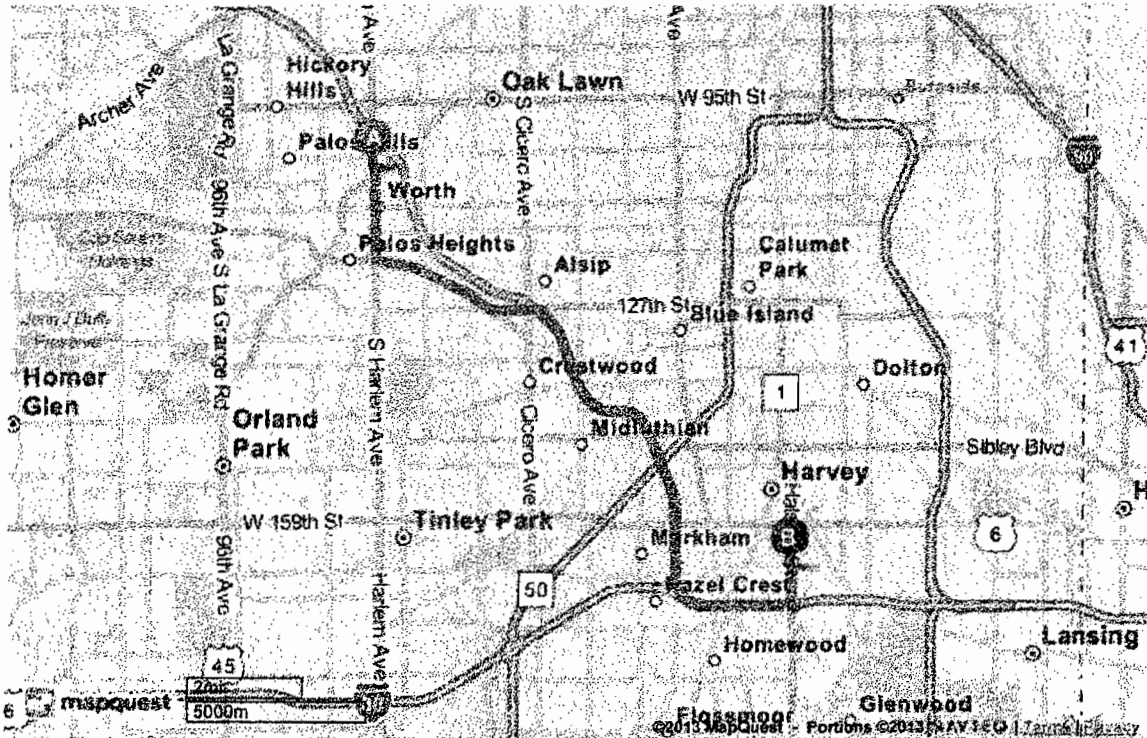
[10451-10548] S Harlem Ave, Palos Hills, IL 60465

1. Start out going south on **S Harlem Ave / IL-43** toward **SouthWest Hwy / IL-7**. [Map](#) 1.7 Mi
1.7 Mi Total
2. Turn **left** onto **W College Dr / IL-83**. Continue to follow **IL-83**. [Map](#) 2.5 Mi
4.2 Mi Total
*IL-83 is 0.3 miles past W 116th St
 Sherwin-Williams Paint Store is on the corner
 If you reach W 119th Pl you've gone a little too far*
3. Turn **slight left** onto **W 127th St / IL-83**. Continue to follow **W 127th St**. [Map](#) 1.0 Mi
5.2 Mi Total
*W 127th St is 0.3 miles past S Central Ave
 SPEEDWAY #7750 is on the corner
 If you are on Cal Sag Rd and reach W Playfield Dr you've gone a little too far*
4. Merge onto **I-294 S** toward **Indiana** (Portions toll). [Map](#) 8.6 Mi
13.8 Mi Total
If you reach S Kostner Ave you've gone about 0.2 miles too far
- EXIT** 5. Take the **IL-1 / Halsted St** exit. [Map](#) 0.3 Mi
14.0 Mi Total
- RAMP** 6. Keep left to take the ramp toward **IL-1 N / Halsted St**. [Map](#) 0.3 Mi
14.4 Mi Total
7. Merge onto **IL-1 N / Halsted St**. [Map](#) 0.9 Mi
15.2 Mi Total
8. **16641 HALSTED ST STE 1** is on the right. [Map](#)
*Your destination is just past E 167th St
 If you reach E 166th St you've gone a little too far*

16641 Halsted St Ste 1, Harvey, IL 60426-6174

Total Travel Estimate: 15.24 miles - about 25 minutes

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Notes

South Holland Renal Center

Trip to:

16136 S Park Ave

South Holland, IL 60473-1511

14.85 miles / 29 minutes



[10451-10548] S Harlem Ave, Palos Hills, IL 60465



1. Start out going south on S Harlem Ave / IL-43 toward SouthWest Hwy / IL-7.

[Map](#)

1.7 Mi

1.7 Mi Total



83

2. Turn left onto W College Dr / IL-83. Continue to follow IL-83. [Map](#)

IL-83 is 0.3 miles past W 116th St

Sherwin-Williams Paint Store is on the corner

If you reach W 119th Pl you've gone a little too far

2.5 Mi

4.2 Mi Total



3. Turn slight left onto W 127th St / IL-83. Continue to follow W 127th St. [Map](#)

W 127th St is 0.3 miles past S Central Ave

SPEEDWAY #7750 is on the corner

If you are on Cal Sag Rd and reach W Playfield Dr you've gone a little too far

1.0 Mi

5.2 Mi Total



4. Merge onto I-294 S toward Indiana (Portions toll). [Map](#)

If you reach S Kostner Ave you've gone about 0.2 miles too far

5.0 Mi

10.2 Mi Total



5. Take the exit. [Map](#)

0.2 Mi

10.4 Mi Total



6

6. Merge onto US-6 via the ramp on the left. [Map](#)

4.4 Mi

14.8 Mi Total



7. Turn left onto S Park Ave. [Map](#)

S Park Ave is just past Louis Ave

Chase Bank is on the left

If you reach Claire Ln you've gone about 0.1 miles too far

0.08 Mi

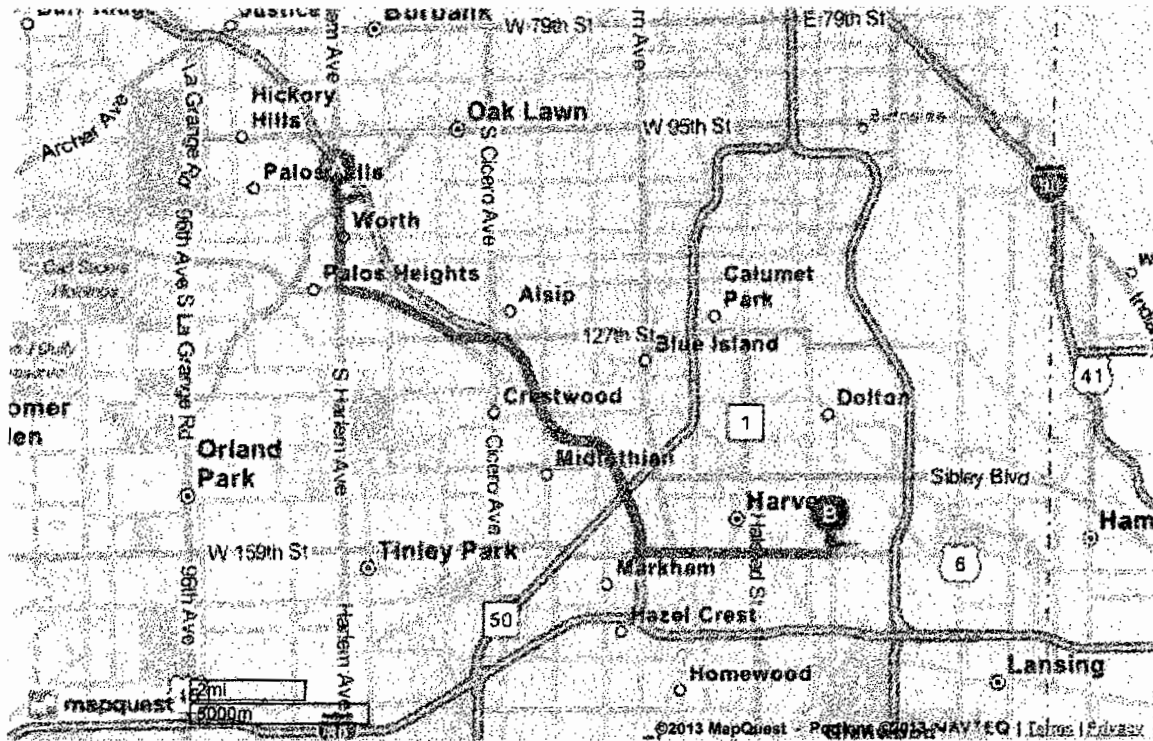
14.8 Mi Total



16136 S Park Ave, South Holland, IL 60473-1511

Total Travel Estimate: 14.85 miles - about 29 minutes

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Notes

FMC - Merrionette Park

Trip to:

11630 S Kedzie Ave

Merrionette Park, IL 60803-6302

6.42 miles / 15 minutes



[10451-10548] S Harlem Ave, Palos Hills, IL 60465



1. Start out going south on S Harlem Ave / IL-43 toward SouthWest Hwy / IL-7.

[Map](#)

0.7 Mi

0.7 Mi Total



2. Turn left onto W 111th St. [Map](#)

W 111th St is just past W 110th Pl

Post Office-Worth is on the corner

If you reach W 111th Pl you've gone a little too far

1.0 Mi

1.7 Mi Total



3. Turn right onto S Ridgeland Ave. [Map](#)

S Ridgeland Ave is just past S Nagle Ave

If you reach Oxford Ave you've gone a little too far

0.5 Mi

2.2 Mi Total



4. Take the 1st left onto W 115th St. [Map](#)

W 115th St is 0.1 miles past W 114th St

If you reach W Wood Ave you've gone about 0.1 miles too far

4.0 Mi

6.2 Mi Total



5. Turn right onto S Kedzie Ave. [Map](#)

S Kedzie Ave is just past S La Salle St

Mobil is on the corner

If you reach S Troy St you've gone a little too far

0.2 Mi

6.4 Mi Total



6. **11630 S KEDZIE AVE** is on the right. [Map](#)

Your destination is 0.1 miles past W Meadow Lane Dr

If you reach W 116th Pl you've gone a little too far



11630 S Kedzie Ave, Merrionette Park, IL 60803-6302



mapquest

Notes

Mount Greenwood Dialysis

Trip to:

3401 W 111th St

Chicago, IL 60655-3329

5.45 miles / 13 minutes



[10451-10548] S Harlem Ave, Palos Hills, IL 60465



1. Start out going **south** on **S Harlem Ave / IL-43** toward **SouthWest Hwy / IL-7**.

0.7 Mi

[Map](#)

0.7 Mi Total



2. Turn **left** onto **W 111th St**. [Map](#)

4.7 Mi

W 111th St is just past W 110th Pl

5.4 Mi Total

Post Office-Worth is on the corner

If you reach W 111th Pl you've gone a little too far



3. **3401 W 111TH ST** is on the **right**. [Map](#)

Your destination is just past S Trumbull Ave

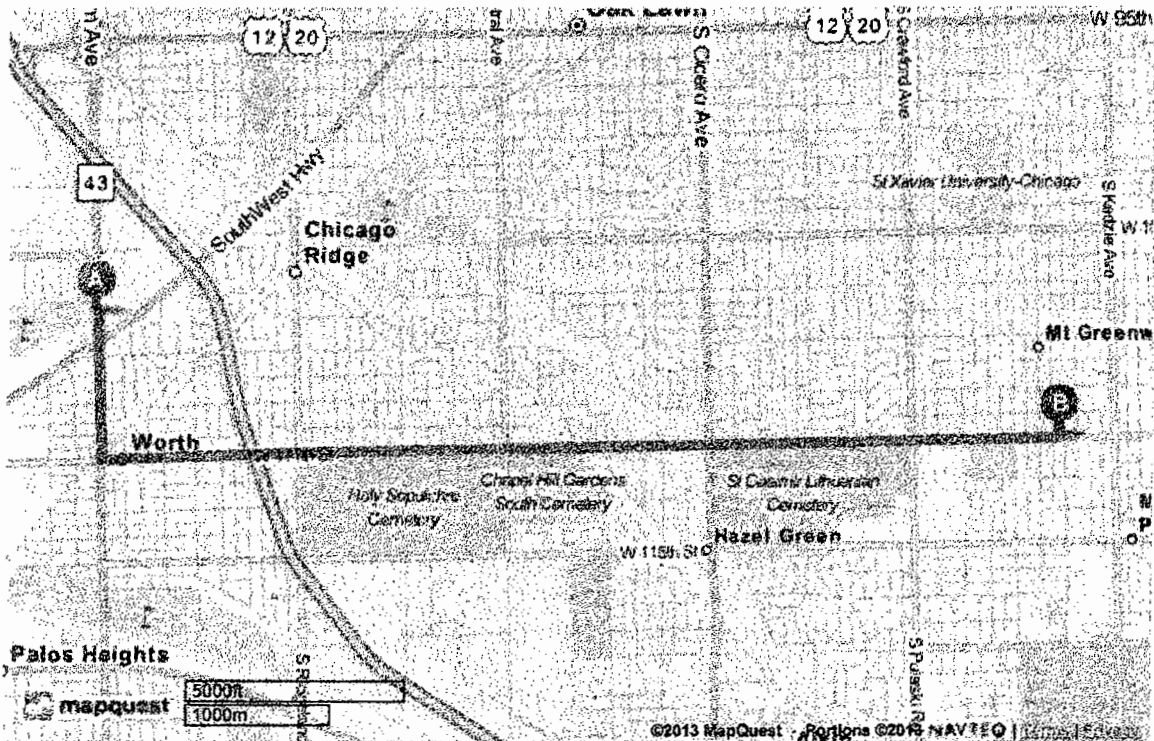
If you reach S Homan Ave you've gone a little too far



3401 W 111th St, Chicago, IL 60655-3329

Total Travel Estimate: 5.45 miles - about 13 minutes

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Notes

Fresenius Medical Care Evergreen Park

Trip to:

9730 S Western Ave

Evergreen Park, IL 60805-2814

7.11 miles / 19 minutes



[10451-10548] S Harlem Ave, Palos Hills, IL 60465



1. Start out going **south** on **S Harlem Ave / IL-43** toward **SouthWest Hwy / IL-7**.

[Map](#)

0.1 Mi

0.1 Mi Total



2. Take the 1st **left** onto **SouthWest Hwy**. [Map](#)

Brooklyn Pizza is on the corner

If you reach W 107th St you've gone a little too far

2.1 Mi

2.3 Mi Total



20

3. Turn **right** onto **US-20 / US-12 / W 95th St**. [Map](#)

US-20 is 0.1 miles past Austin Ave

Red Lobster is on the left

If you reach W 93rd St you've gone about 0.2 miles too far

4.5 Mi

6.7 Mi Total



4. Turn **right** onto **S Western Ave**. [Map](#)

S Western Ave is 0.1 miles past S Campbell Ave

Applebee's is on the right

If you reach S Claremont Ave you've gone a little too far

0.4 Mi

7.1 Mi Total



5. **9730 S WESTERN AVE** is on the **right**. [Map](#)

Your destination is 0.1 miles past W 97th St

If you reach W 99th St you've gone about 0.1 miles too far



9730 S Western Ave, Evergreen Park, IL 60805-2814

Total Travel Estimate: 7.11 miles - about 19 minutes

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Notes

Beverly Dialysis

Trip to:

8111 S Western Ave

Chicago, IL 60620-5939

7.85 miles / 19 minutes



[10451-10548] S Harlem Ave, Palos Hills, IL 60465



1. Start out going south on S Harlem Ave / IL-43 toward SouthWest Hwy / IL-7.

0.1 Mi

[Map](#)

0.1 Mi Total



2. Take the 1st left onto SouthWest Hwy. [Map](#)

4.9 Mi

Brooklyn Pizza is on the corner

5.1 Mi Total

If you reach W 107th St you've gone a little too far



3. Turn slight right onto W 87th St. [Map](#)

2.1 Mi

W 87th St is 0.2 miles past S Merion Ln

7.1 Mi Total

If you are on W Columbus Ave and reach S Pulaski Rd you've gone a little too far



4. Turn left onto S Western Ave. [Map](#)

0.7 Mi

If you reach S Longwood Dr you've gone about 0.3 miles too far

7.9 Mi Total



5. **8111 S WESTERN AVE** is on the right. [Map](#)

Your destination is just past W 81st Pl

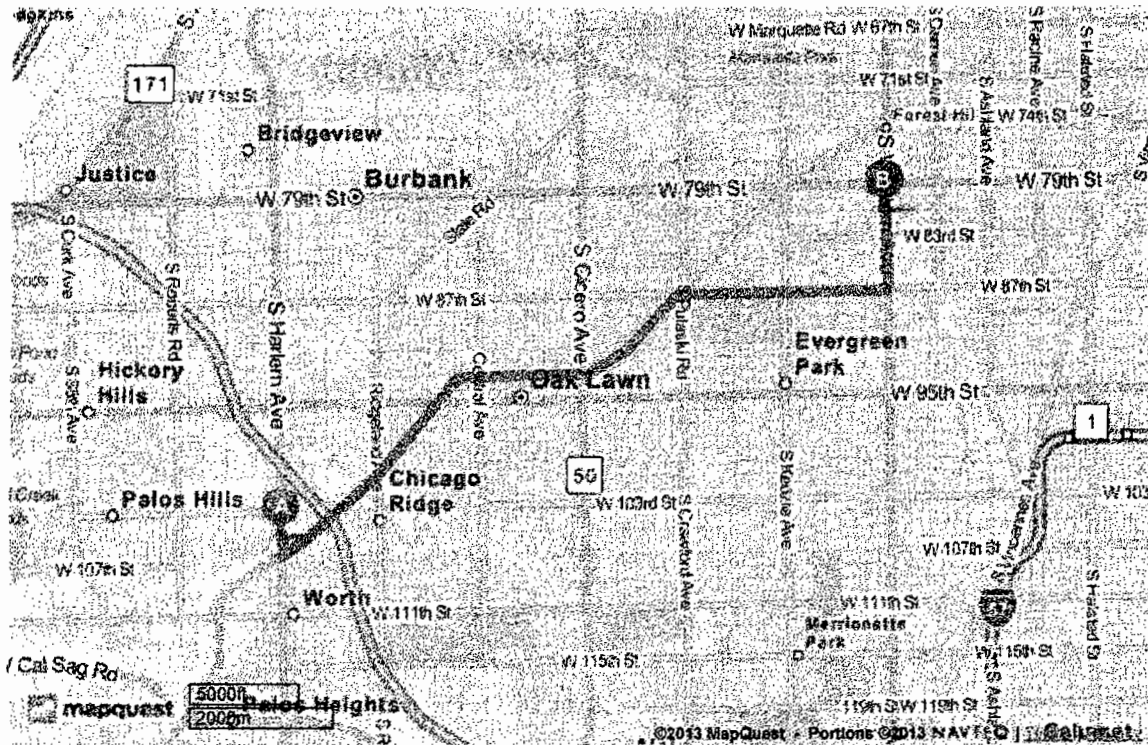
If you reach W 81st St you've gone a little too far



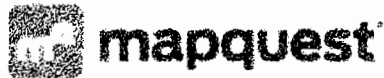
8111 S Western Ave, Chicago, IL 60620-5939

Total Travel Estimate: 7.85 miles - about 19 minutes

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Notes

Fresenius Medical Care Chatham

Trip to:

8710 S Holland Rd

Chicago, IL 60620

9.77 miles / 25 minutes



[10451-10548] S Harlem Ave, Palos Hills, IL 60465



1. Start out going south on **S Harlem Ave / IL-43** toward **SouthWest Hwy / IL-7**.

[Map](#)

0.1 Mi

0.1 Mi Total



2. Take the 1st **left** onto **SouthWest Hwy**. [Map](#)

Brooklyn Pizza is on the corner

If you reach W 107th St you've gone a little too far

4.9 Mi

5.1 Mi Total



3. Turn **slight right** onto **W 87th St**. [Map](#)

W 87th St is 0.2 miles past S Merion Ln

If you are on W Columbus Ave and reach S Pulaski Rd you've gone a little too far

4.6 Mi

9.7 Mi Total



4. Turn **slight right** onto **S Holland Rd**. [Map](#)

Reggio's Pizza is on the corner

If you reach S Lafayette Ave you've gone about 0.3 miles too far

0.07 Mi

9.8 Mi Total



5. **8710 S HOLLAND RD** is on the **right**. [Map](#)

Your destination is just past S Princeton Ave

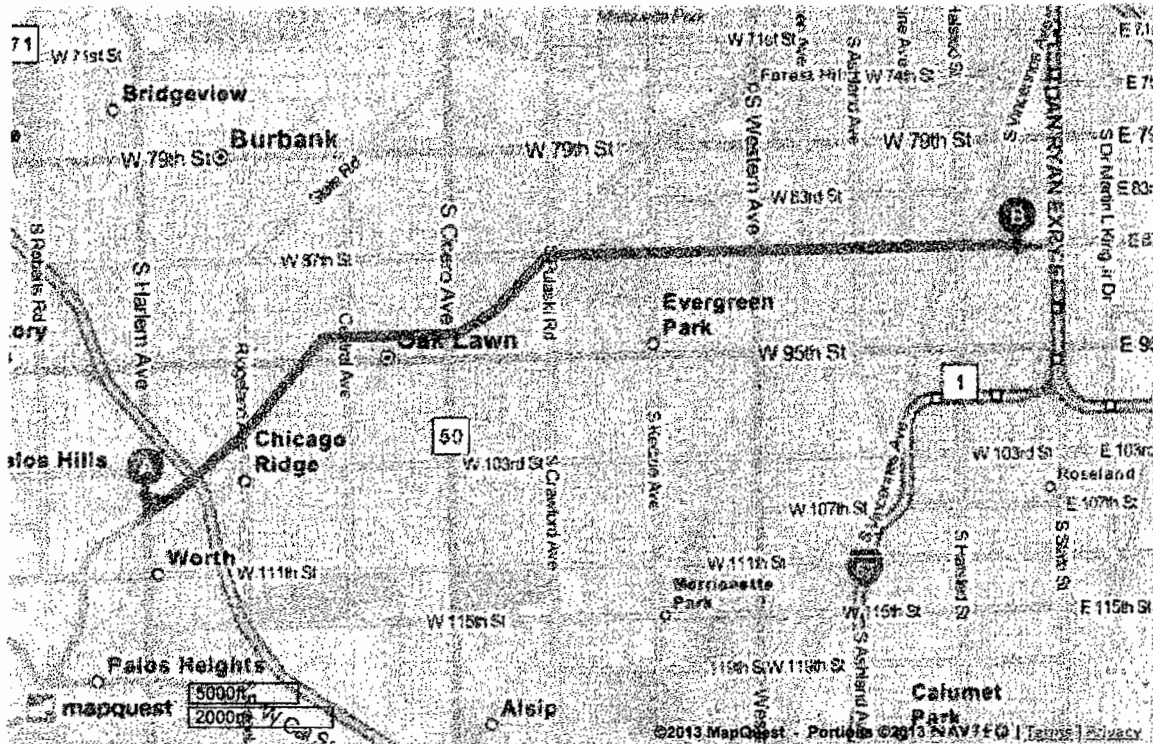
If you reach W 88th St you've gone a little too far



8710 S Holland Rd, Chicago, IL 60620

Total Travel Estimate: 9.77 miles - about 25 minutes

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Notes

FMC - Southside

Trip to:

3134 W 76th St

Chicago, IL 60652-1968

6.92 miles / 18 minutes



[10451-10548] S Harlem Ave, Palos Hills, IL 60465



1. Start out going **south** on **S Harlem Ave / IL-43** toward **SouthWest Hwy / IL-7**.
[Map](#)

0.1 Mi

0.1 Mi Total



2. Take the **1st left** onto **SouthWest Hwy**. [Map](#)

4.9 Mi

Brooklyn Pizza is on the corner

If you reach W 107th St you've gone a little too far

5.1 Mi Total



3. **SouthWest Hwy** becomes **W Columbus Ave**. [Map](#)

1.5 Mi

6.6 Mi Total



4. Turn **left** onto **S Kedzie Ave**. [Map](#)

0.3 Mi

S Kedzie Ave is just past W 79th St

If you reach S Troy St you've gone a little too far

6.9 Mi Total



5. Take the **2nd right** onto **W 76th St**. [Map](#)

0.03 Mi

W 76th St is 0.1 miles past W 77th St

If you reach W 73rd St you've gone about 0.3 miles too far

6.9 Mi Total



6. **3134 W 76TH ST** is on the **left**. [Map](#)

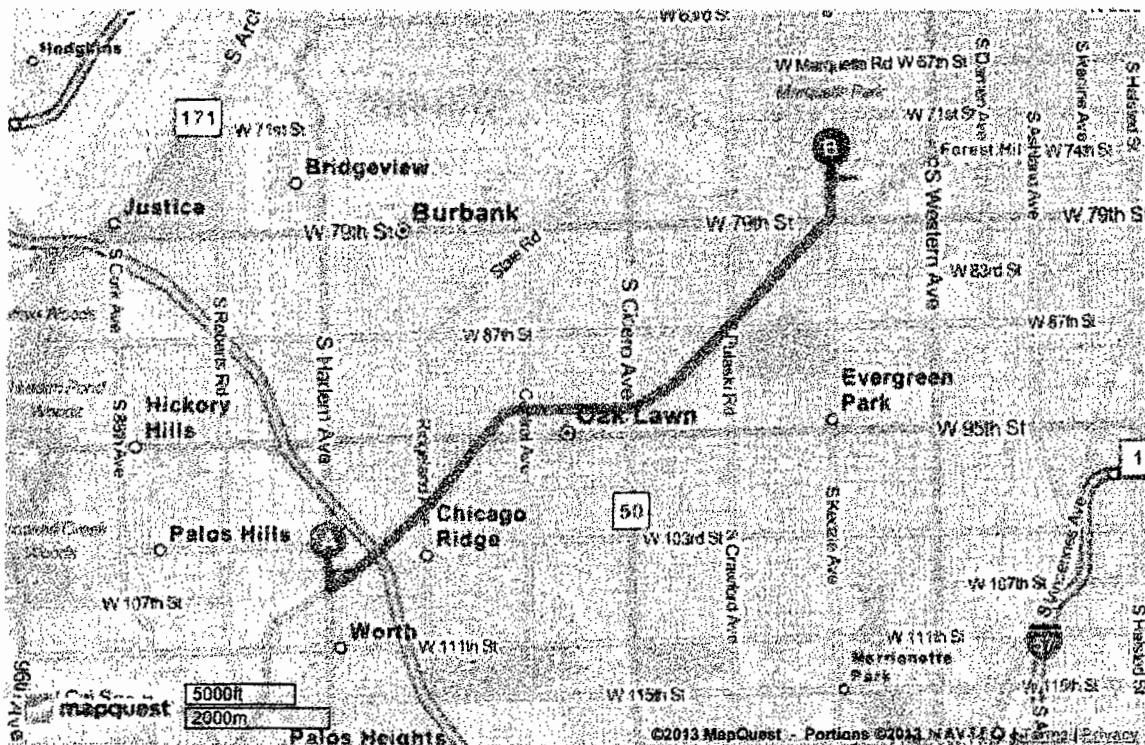
If you reach W 77th St you've gone about 0.1 miles too far



3134 W 76th St, Chicago, IL 60652-1968

Total Travel Estimate: 6.92 miles - about 18 minutes

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Notes

FMC - Neomedica - Marquette Park

Trip to:

6535 S Western Ave

Chicago, IL 60636-2410

8.81 miles / 22 minutes



[10451-10548] S Harlem Ave, Palos Hills, IL 60465



1. Start out going south on **S Harlem Ave / IL-43** toward **SouthWest Hwy / IL-7**.
[Map](#)

0.1 Mi

0.1 Mi Total



2. Take the 1st left onto **SouthWest Hwy**. [Map](#)

4.9 Mi

Brooklyn Pizza is on the corner

If you reach W 107th St you've gone a little too far

5.1 Mi Total



3. **SouthWest Hwy** becomes **W Columbus Ave**. [Map](#)

2.7 Mi

7.7 Mi Total



4. Turn left onto **S Western Ave**. [Map](#)

1.1 Mi

Second Mt Calvary MB Church is on the corner

8.8 Mi Total



5. **6535 S WESTERN AVE** is on the right. [Map](#)

Your destination is just past W 66th St

If you reach W 65th St you've gone a little too far



6535 S Western Ave, Chicago, IL 60636-2410



mapquest

Trip to:

6333 S Green St

Chicago, IL 60621-1943


11.11 miles / 29 minutes


Notes


FMC - Ross Dialysis - Englewood





[10451-10548] S Harlem Ave, Palos Hills, IL 60465


- 


1. Start out going **south** on **S Harlem Ave / IL-43** toward **SouthWest Hwy / IL-7**. [Map](#) 0.1 Mi
0.1 Mi Total
- 


2. Take the 1st **left** onto **SouthWest Hwy**. [Map](#) 4.9 Mi
Brooklyn Pizza is on the corner 5.1 Mi Total
If you reach W 107th St you've gone a little too far
- 


3. **SouthWest Hwy** becomes **W Columbus Ave**. [Map](#) 2.7 Mi
7.7 Mi Total
- 

4. Turn **left** onto **S Western Ave**. [Map](#) 0.9 Mi
Second Mt Calvary MB Church is on the corner 8.6 Mi Total
- 

5. Turn **right** onto **W Marquette Rd / W 67th St**. [Map](#) 1.5 Mi
W Marquette Rd is 0.1 miles past W 68th St 10.1 Mi Total
If you reach W 66th St you've gone about 0.1 miles too far
- 

6. Turn **left** onto **S Racine Ave**. [Map](#) 0.5 Mi
S Racine Ave is just past S Elizabeth St 10.6 Mi Total
Island Fish & Chicken is on the corner
If you reach S May St you've gone a little too far
- 

7. Turn **right** onto **W 63rd St**. [Map](#) 0.4 Mi
W 63rd St is 0.1 miles past W 64th St 11.0 Mi Total
Brothers Submarine is on the corner
If you reach W 62nd St you've gone about 0.1 miles too far
- 

8. Turn **right** onto **S Green St**. [Map](#) 0.06 Mi
S Green St is just past S Peoria St 11.1 Mi Total
U.S. Bank - Englewood IL Office is on the corner
If you reach S Halsted St you've gone a little too far
- 

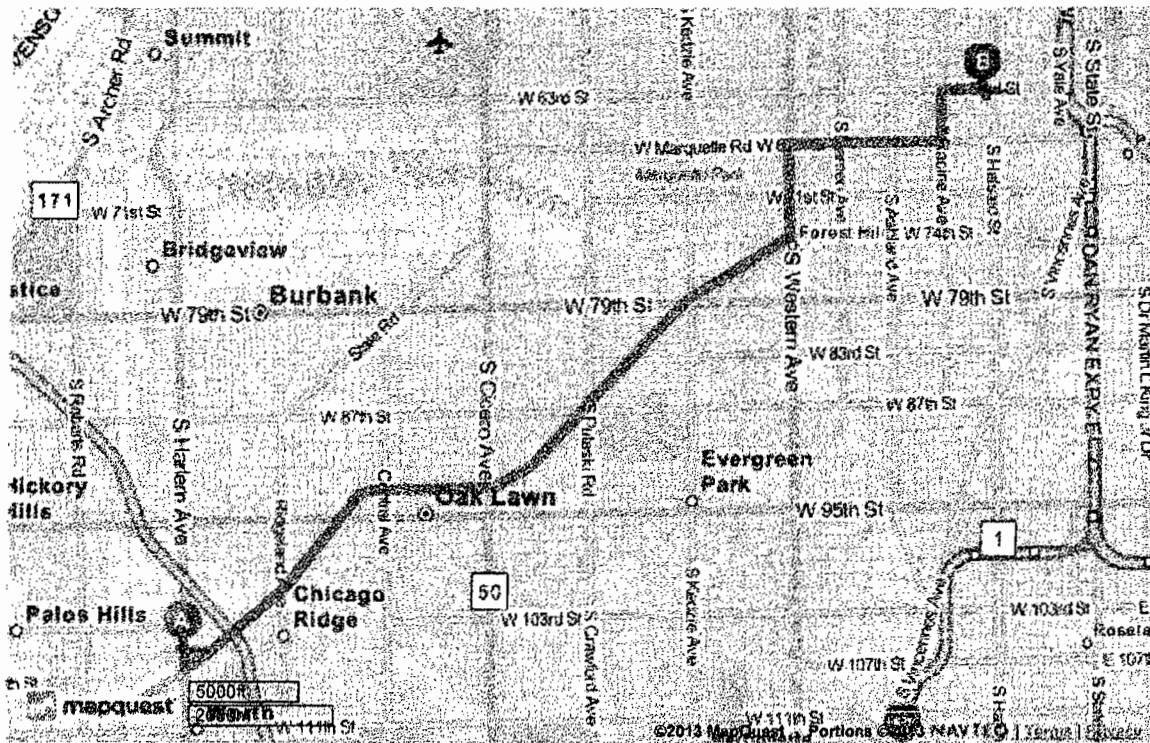
9. **6333 S GREEN ST** is on the **left**. [Map](#)



6333 S Green St, Chicago, IL 60621-1943

Total Travel Estimate: 11.11 miles - about 29 minutes

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Trip to:

5401 S Wentworth Ave

Chicago, IL 60609-6300

16.60 miles / 32 minutes

Notes

FMC - Garfield



[10451-10548] S Harlem Ave, Palos Hills, IL 60465



1. Start out going south on S Harlem Ave / IL-43 toward SouthWest Hwy / IL-7.
[Map](#)

0.7 Mi

0.7 Mi Total



2. Turn left onto W 111th St. [Map](#)

6.6 Mi

W 111th St is just past W 110th Pl
Post Office-Worth is on the corner
If you reach W 111th Pl you've gone a little too far

7.3 Mi Total



3. W 111th St becomes W Monterey Ave. [Map](#)

0.3 Mi

7.6 Mi Total



4. Turn left onto S Vincennes Ave. [Map](#)

0.2 Mi

S Vincennes Ave is just past S Church St
Morgan Park Pentecostal Church is on the corner
If you reach S Ashland Ave you've gone a little too far

7.8 Mi Total



5. Turn right onto W 111th St. [Map](#)

0.2 Mi

W 111th St is just past W Pryor Ave
Church of Jesus Christ of Latter-Day Saints is on the right
If you reach W Chelsea Pl you've gone a little too far

8.0 Mi Total



6. Merge onto I-57 N via the ramp on the left toward Chicago Loop. [Map](#)

2.6 Mi

If you reach S Bishop St you've gone a little too far

10.6 Mi Total



7. Merge onto I-94 W / Dan Ryan Expy W via the exit on the left toward Chicago Loop. [Map](#)

4.0 Mi

14.6 Mi Total



8. Keep right to take I-94 W / Dan Ryan Expy W. [Map](#)

1.5 Mi

16.1 Mi Total



9. Take EXIT 57 toward Garfield Blvd. [Map](#)

0.3 Mi

16.4 Mi Total



10. Stay straight to go onto S Wentworth Ave. [Map](#)

0.2 Mi

16.6 Mi Total



11. 5401 S WENTWORTH AVE is on the right. [Map](#)

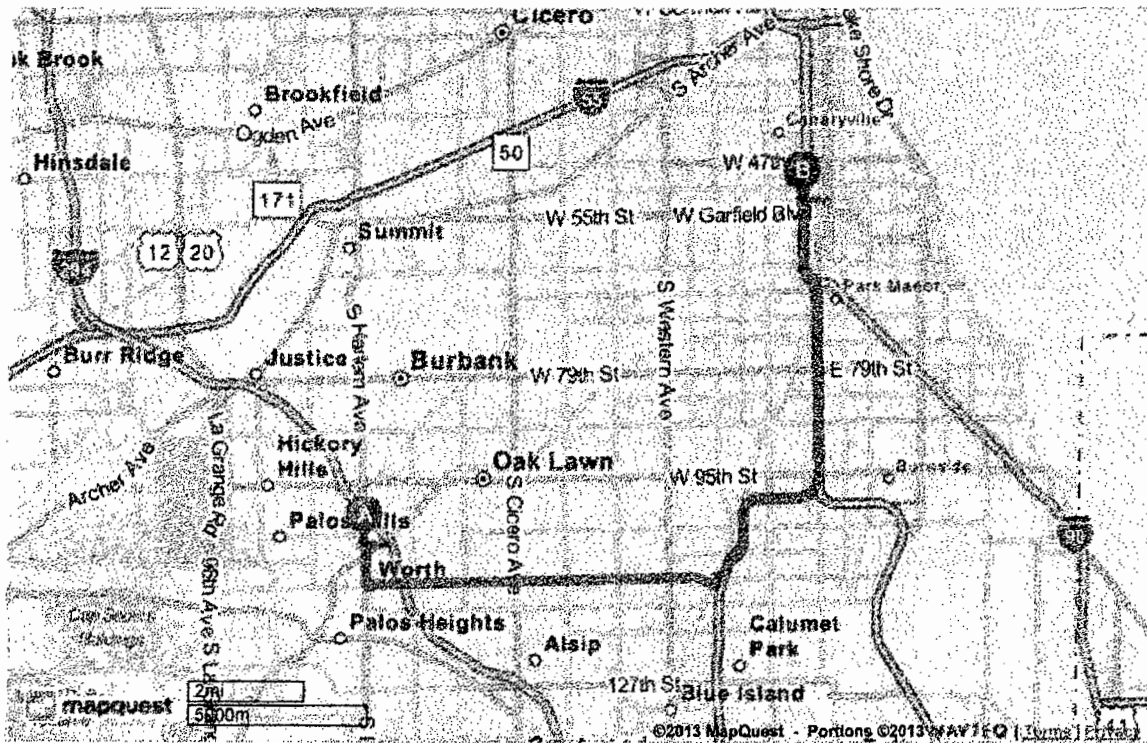
Your destination is 0.1 miles past W Garfield Blvd
If you reach W 53rd St you've gone about 0.1 miles too far



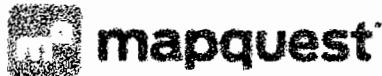
5401 S Wentworth Ave, Chicago, IL 60609-6300

Total Travel Estimate: 16.60 miles - about 32 minutes

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Trip to:

710 W 43rd St

Chicago, IL 60609-3435

18.96 miles / 32 minutes

Notes

Emerald Dialysis



[10451-10548] S Harlem Ave, Palos Hills, IL 60465



1. Start out going north on S Harlem Ave / IL-43 N toward W 105th St. [Map](#)

6.9 Mi

6.9 Mi Total



2. Merge onto I-55 N / Stevenson Expy N. [Map](#)

8.6 Mi

If you reach IL-43 S you've gone about 0.4 miles too far

15.5 Mi Total



3. Merge onto I-90 E / I-94 E / Dan Ryan Expy E via EXIT 292B toward Indiana. [Map](#)

0.8 Mi

16.2 Mi Total



4. Keep right to take I-90 E / I-94 E / Dan Ryan Expy E. [Map](#)

1.9 Mi

18.1 Mi Total



5. Take EXIT 56A toward 43rd St. [Map](#)

0.2 Mi

18.3 Mi Total



6. Turn slight left onto S Wentworth Ave. [Map](#)

0.03 Mi

Subway is on the corner

18.3 Mi Total



7. Take the 1st right onto W 43rd St. [Map](#)

0.6 Mi

DAN RYAN CITGO is on the corner

If you reach W 43rd Pl you've gone a little too far

19.0 Mi Total



8. 710 W 43RD ST is on the right. [Map](#)

Your destination is just past S Union Ave

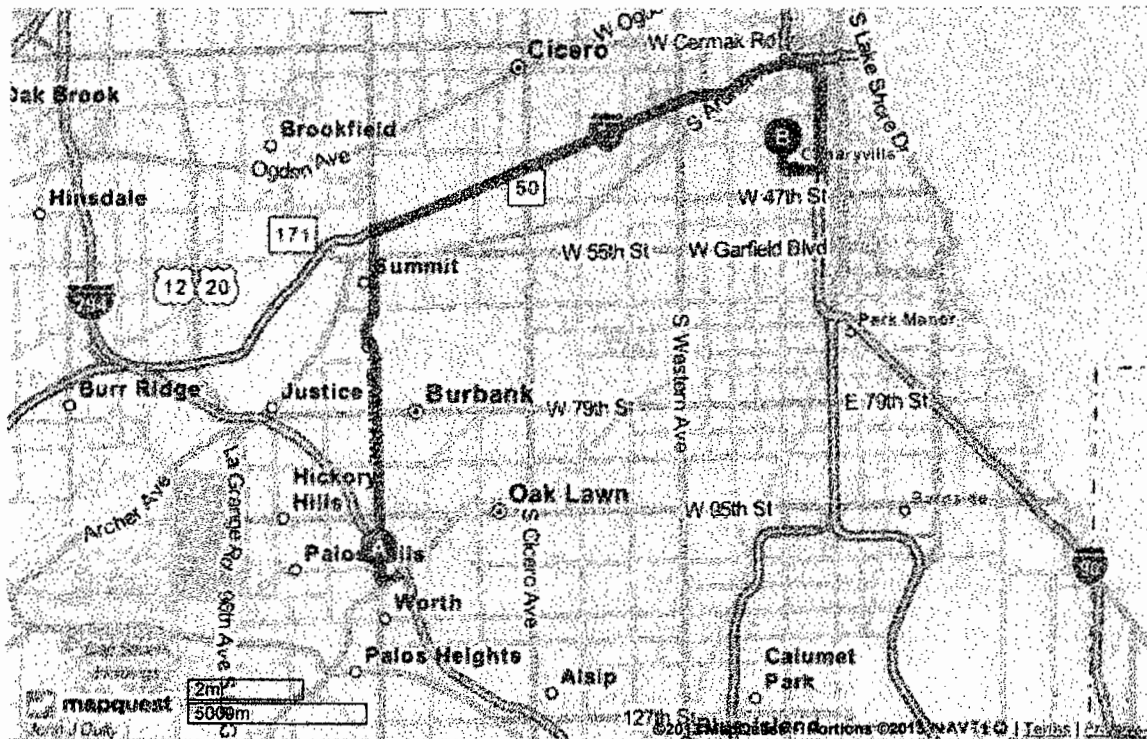
If you reach S Emerald Ave you've gone a little too far



710 W 43rd St, Chicago, IL 60609-3435

Total Travel Estimate: 18.96 miles - about 32 minutes

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Notes

Fresenius Medical Care Bridgeport

Trip to:

825 W 35th St

Chicago, IL 60609-1511

15.84 miles / 29 minutes



[10451-10548] S Harlem Ave, Palos Hills, IL 60465



1. Start out going north on **S Harlem Ave / IL-43 N** toward **W 105th St**. [Map](#)

6.9 Mi

6.9 Mi Total



2. Merge onto **I-55 N / Stevenson Expy N**. [Map](#)

6.6 Mi

If you reach IL-43 S you've gone about 0.4 miles too far

13.5 Mi Total



3. Take the **Damen Ave** exit, **EXIT 290**, toward **Ashland Ave**. [Map](#)

0.2 Mi

13.7 Mi Total



4. Keep **left** to take the **Damen Ave** ramp. [Map](#)

0.2 Mi

13.9 Mi Total



5. Keep **right** at the fork to go on **S Damen Ave**. [Map](#)

0.5 Mi

14.4 Mi Total



6. Turn **left** onto **W 35th St**. [Map](#)

1.4 Mi

W 35th St is just past W 34th Pl

China Wok is on the left

If you reach W 36th St you've gone about 0.1 miles too far

15.8 Mi Total



7. **825 W 35TH ST** is on the **right**. [Map](#)

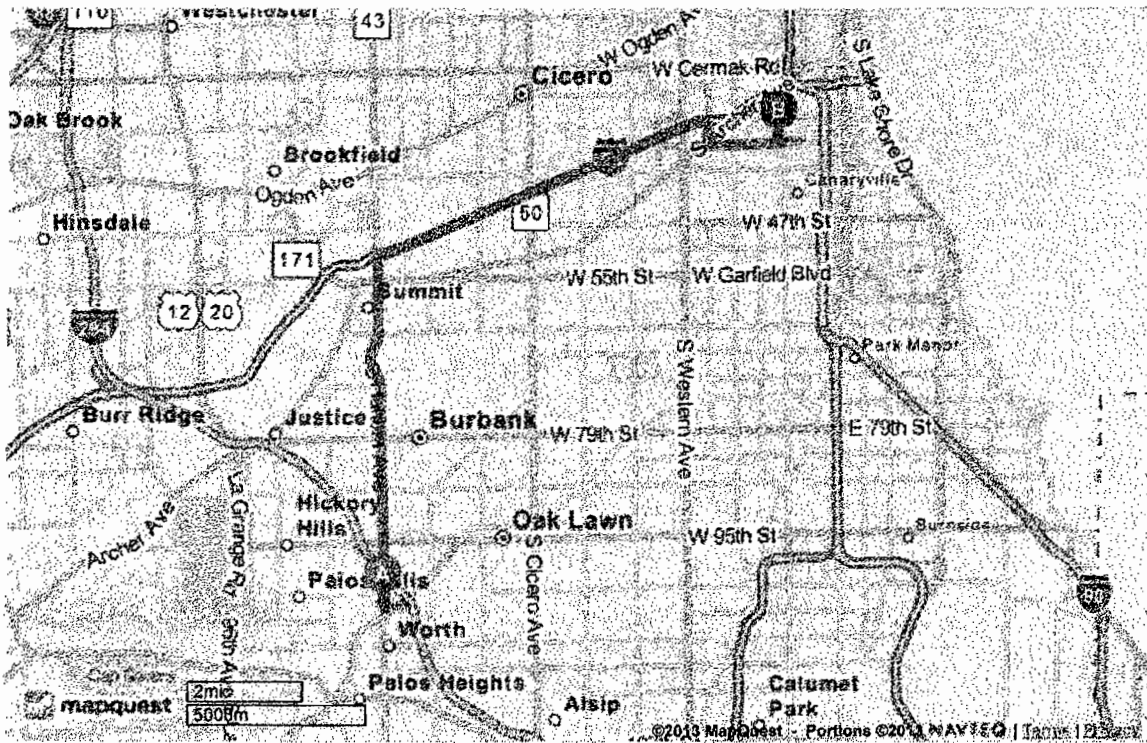
If you reach S Haisted St you've gone a little too far



825 W 35th St, Chicago, IL 60609-1511

Total Travel Estimate: 15.84 miles - about 29 minutes

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Notes

Fresenius Medical Care of Roseland

Trip to:

132 W 111th St

Chicago, IL 60628-4215

9.65 miles / 25 minutes



[10451-10548] S Harlem Ave, Palos Hills, IL 60465



1. Start out going **south** on **S Harlem Ave / IL-43** toward **SouthWest Hwy / IL-7**.

0.7 Mi

[Map](#)

0.7 Mi Total



2. Turn **left** onto **W 111th St**. [Map](#)

6.6 Mi

W 111th St is just past W 110th Pl

7.3 Mi Total

Post Office-Worth is on the corner

If you reach W 111th Pl you've gone a little too far



3. **W 111th St** becomes **W Monterey Ave**. [Map](#)

0.3 Mi

7.6 Mi Total



4. Turn **left** onto **S Vincennes Ave**. [Map](#)

0.2 Mi

S Vincennes Ave is just past S Church St

7.8 Mi Total

Morgan Park Pentecostal Church is on the corner

If you reach S Ashland Ave you've gone a little too far



5. Turn **right** onto **W 111th St**. [Map](#)

1.9 Mi

W 111th St is just past W Pryor Ave

9.7 Mi Total

Church of Jesus Christ of Latter-Day Saints is on the right

If you reach W Chelsea Pl you've gone a little too far



6. **132 W 111TH ST** is on the **left**. [Map](#)

Your destination is just past S Wentworth Ave

If you reach S Perry Ave you've gone a little too far



132 W 111th St, Chicago, IL 60628-4215



Notes

FMC - Greenwood Dialysis Center

Trip to:

1111 E 87th St Ste 700

Chicago, IL 60619-7038

11.52 miles / 30 minutes



[10451-10548] S Harlem Ave, Palos Hills, IL 60465



1. Start out going **south** on **S Harlem Ave / IL-43** toward **SouthWest Hwy / IL-7**.

0.1 Mi

[Map](#)

0.1 Mi Total



2. Take the 1st **left** onto **SouthWest Hwy**. [Map](#)

4.9 Mi

Brooklyn Pizza is on the corner

5.1 Mi Total

If you reach W 107th St you've gone a little too far



3. Turn **slight right** onto **W 87th St**. [Map](#)

6.5 Mi

W 87th St is 0.2 miles past S Merrion Ln

11.5 Mi Total

If you are on W Columbus Ave and reach S Pulaski Rd you've gone a little too far



4. **1111 E 87TH ST STE 700** is on the **right**. [Map](#)

Your destination is just past S Greenwood Ave

If you reach S Avalon Ave you've gone about 0.1 miles too far



1111 E 87th St Ste 700, Chicago, IL 60619-7038



mapquest

Notes

Approved site for NxStage Oak Brook to proposed site for Chicago Ridge Dialysis

Trip to:

[10600 - 10612] S Harlem Ave

Worth, IL 60482-1247

16.99 miles / 19 minutes



1600 16th St, Oak Brook, IL 60523-1358

Download
Free App



1. Start out going **east** on **16th St** toward **IL Route 83 / IL-83**. [Map](#)



2. Take the 1st **right** onto **IL Route 83 / IL-83**. Continue to follow **IL-83**. [Map](#)
Suresh Rajan - State Farm Insurance Agent is on the left
If you reach Oakbrook Ctr you've gone about 0.1 miles too far

0.7 Mi

0.7 Mi Total



3. Merge onto **I-88 E / Chicago-Kansas City Expressway E / Ronald Reagan Memorial Tollway E** toward **Chicago** (Portions toll). [Map](#)

1.6 Mi

2.2 Mi Total



4. Keep **right** to take **I-294 S** toward **Indiana** (Portions toll). [Map](#)

12.8 Mi

15.0 Mi Total



5. Merge onto **US-20 E / US-12 E / W 95th St**. [Map](#)

0.5 Mi

15.5 Mi Total



6. Merge onto **IL-43 S / S Harlem Ave**. [Map](#)

1.5 Mi

17.0 Mi Total



7. **[10600 - 10612] S HARLEM AVE**. [Map](#)

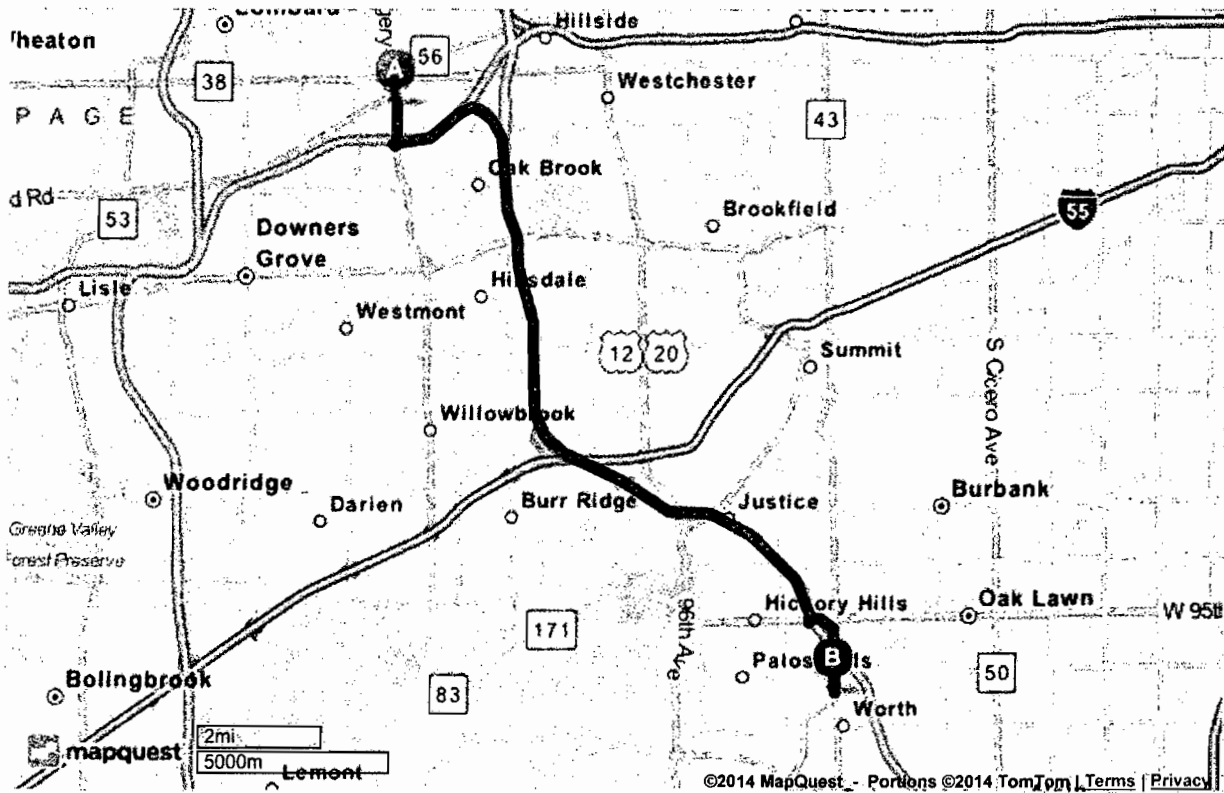
Your destination is 0.1 miles past W 105th St

If you are on IL-43 and reach Southwest Hwy you've gone a little too far



[10600 - 10612] S Harlem Ave, Worth, IL 60482-1247

Total Travel Estimate: 16.99 miles - about 19 minutes



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Notes

Approved site for Nocturnal Dialysis Spa to proposed site for Chicago Ridge Dialysis

Trip to:

[10600 - 10612] S Harlem Ave

Worth, IL 60482-1247

18.00 miles / 21 minutes



1634 S Ardmore Ave, Villa Park, IL 60181-3407

**Download
Free App**



1. Start out going **south** on **S Ardmore Ave** toward **Lombard Cir**. [Map](#)

0.2 Mi

0.2 Mi Total



2. Turn **left** onto **E Roosevelt Rd / IL-38**. [Map](#)

2.9 Mi

E Roosevelt Rd is just past Lombard Cir

Oakbrook Terrace Citgo is on the corner

If you are on Ardmore Ave and reach Param Apartments you've gone about 0.1 miles too far

3.0 Mi Total



3. Merge onto **I-294 S / Tri State Tollway S** toward **Indiana** (Portions toll). [Map](#)

13.0 Mi

16.0 Mi Total



4. Merge onto **US-20 E / US-12 E / W 95th St**. [Map](#)

0.5 Mi

16.5 Mi Total



5. Merge onto **IL-43 S / S Harlem Ave**. [Map](#)

1.5 Mi

18.0 Mi Total



6. **[10600 - 10612] S HARLEM AVE**. [Map](#)

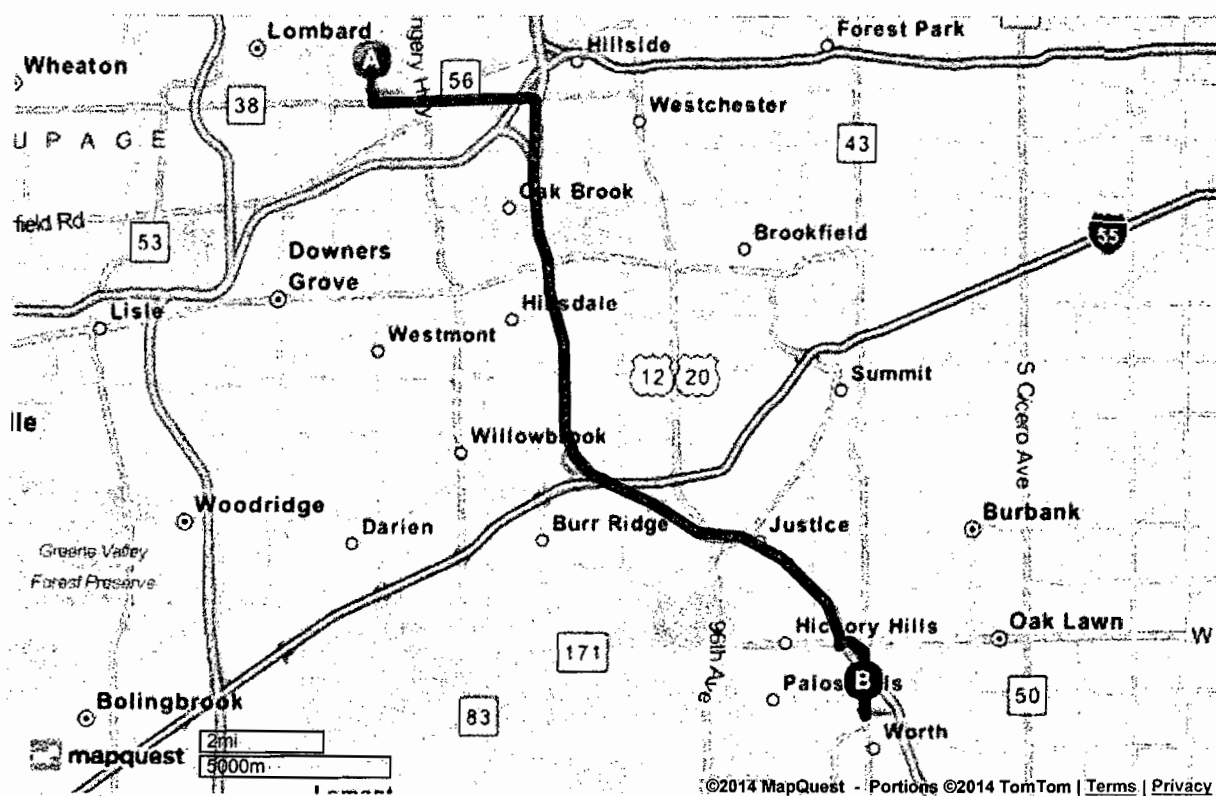
Your destination is 0.1 miles past W 105th St

If you are on IL-43 and reach Southwest Hwy you've gone a little too far



[10600 - 10612] S Harlem Ave, Worth, IL 60482-1247

Total Travel Estimate: 18.00 miles - about 21 minutes



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Trip to:

[10600 - 10612] S Harlem Ave

Worth, IL 60482-1247

13.10 miles / 25 minutes

Notes

Lawndale Dialysis to proposed site for Chicago Ridge
Dialysis



3934 W 24th St, Chicago, IL 60623-3073

Download
Free App



1. Start out going **west** on **W 24th St** toward **S Pulaski Rd.** [Map](#)

0.06 Mi

0.06 Mi Total



2. Take the **1st left** onto **S Pulaski Rd.** [Map](#)

1.7 Mi

Las Islas Marias is on the corner

If you reach S Karlov Ave you've gone a little too far

1.7 Mi Total



3. Merge onto **I-55 S / Adlai E Stevenson Expy S.** [Map](#)

3.9 Mi

5.7 Mi Total



4. Take the **IL-43 / Harlem Ave** exit, **EXIT 283**, toward **7200 W.** [Map](#)

0.3 Mi

6.0 Mi Total



5. Merge onto **Harlem Dr.** [Map](#)

0.09 Mi

6.1 Mi Total



6. Turn **left** onto **IL-43 / Harlem Ave.** [Map](#)

7.0 Mi

If you reach I-55 S you've gone about 0.2 miles too far

13.1 Mi Total



7. **[10600 - 10612] S HARLEM AVE.** [Map](#)

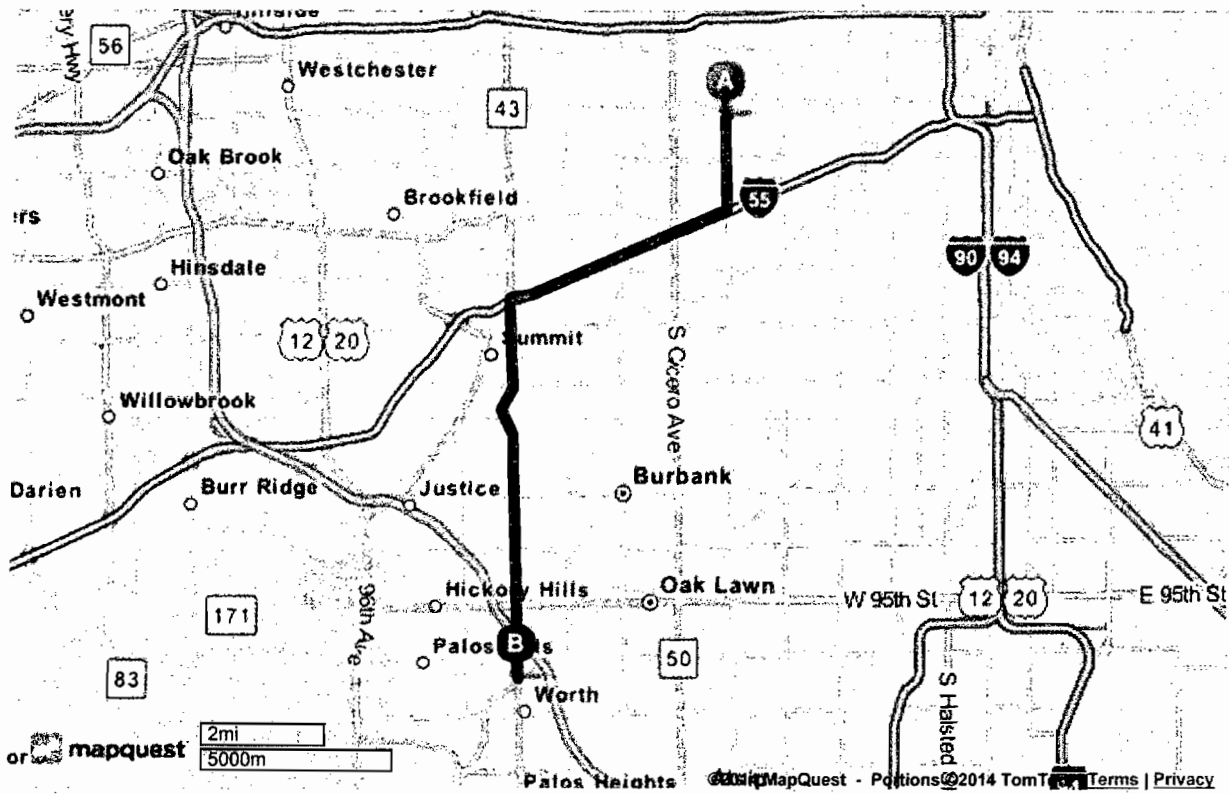
Your destination is 0.1 miles past W 105th St

If you are on IL-43 and reach Southwest Hwy you've gone a little too far



[10600 - 10612] S Harlem Ave, Worth, IL 60482-1247

Total Travel Estimate: 13.10 miles - about 25 minutes



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After paginating the entire, completed application, indicate in the chart below, the page numbers for the attachments included as part of the project's application for permit:

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